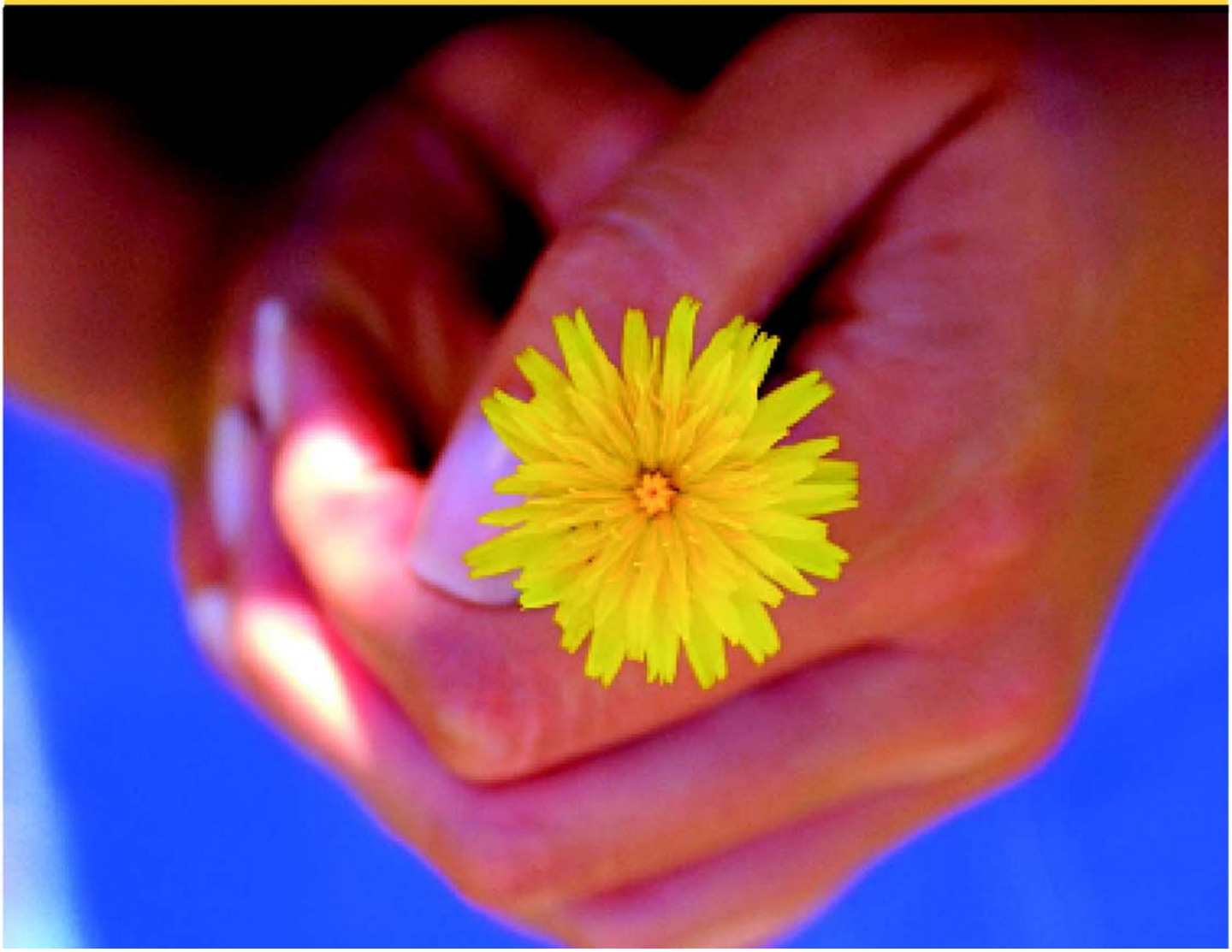
State of Missouri

Comprehensive Plan for Mental Health

Creating Communities of Hope

January 2008 - January 2013



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To ensure 24/7 availability and widest distribution, the Comprehensive Plan for Mental Health is available electronically at:
http://www.dmh.mo.gov/transformation/transformation.htm

Dedication

Missouri's efforts honor Geody Frazier, a consumer leader from Kansas City appointed to the Transformation Working Group, who passed away in May 2007. Geody designed the color scheme to symbolize:

Green: Transformation, Resiliency, Self-determination & Growth

Blue: Hope & Overcoming Stigma

Combined Colors: Awareness & Pride in our Collective Power.

Acknowledgements

Numerous volunteers, experts and citizens contributed to this plan. The Transformation Working Group gratefully acknowledges the valuable input of everyone who participated in the workgroups, public meetings or otherwise provided comments and feedback. Special appreciation to: 1) the Substance Abuse Mental Health Services Administration (SAMHSA) for funding Missouri's Mental Health Transformation State Incentive Grant (MHT SIG) program; 2) the Center for Medicaid and Medicare Services (CMS) for funding for Missouri's Division of Mental Retardation and Developmental Disabilities (MRDD) Transformation Initiative; 3) the Missouri Foundation for Health and the Milbank Memorial Fund for their support of the planning efforts, and 4) The Change Innovation Agency for facilitating the workgroups and guiding the process.

March 31, 2008

Dear Missouri Citizen:

This is a momentous day for Missouri. Through a bipartisan, cross-agency, public-private effort funded by the federal Substance Abuse Mental Health Services Administration (SAMHSA), Missouri has created its first Comprehensive Plan for Mental Health to address the mental health needs of Missourians across the lifespan.

In October, 2006 Governor Matt Blunt accepted a five-year grant award from SAMHSA's Mental Health Transformation State Incentive Grant program to develop and implement a comprehensive plan to transform the mental health system in Missouri. His executive orders 06-39 and 07-15 established the Mental Health Transformation Working Group (TWG) to carry out this charge.

Over the past year, hundreds of Missourians participated in the development of this plan. Six workgroups, comprising nearly 240 content experts, were chartered and 14 public hearings were held across the state. The voices of consumers and families were prominent in shaping the state's mental health priorities. Although the diverse stakeholders involved in this planning effort have not historically spoken with one voice, as the planning progressed it became clear that there are more commonalities than differences regarding mental health issues and that the people across these diverse populations and sectors have much to learn from each other and much to be gained by working together on a common agenda. We sincerely appreciate the enthusiasm and commitment of everyone involved in shaping this plan.

The Comprehensive Plan will move Missouri's mental health system toward a public health approach. Such an approach is driven by the needs of Missouri citizens, grounded in best practices, and designed to improve the overall health and well-being of Missouri's communities. The plan addresses mental health services and access across systems, age groups, cultures and regions. The shared vision and practical blueprint in this plan will guide the collective action needed to create Communities of Hope throughout Missouri that support a system of care where promoting mental health and preventing disabilities is common practice *and* everyone has access to treatment and supports essential for living, learning, working and participating fully in the community.

On behalf of the Mental Health Transformation Working Group, we encourage you to join us in creating Communities of Hope throughout Missouri!

Diane McFarland, Chair
Mental Health Transformation
Working Group

Benton Goon, Co-Chair
Mental Health Transformation
Working Group

MISSOURI Mental Health TRANSFORMATION
Creating Communities of Hope

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Missouri's Vision	**Communities of Hope** throughout Missouri support a system of care where promoting mental health and preventing disabilities is common practice *and* everyone has access to treatment and supports essential for living, learning, working and participating fully in the community.

"Except for world peace, I can't think of a more important project."

Workgroup member

Introduction and Overview

This is a momentous time in Missouri. Through a bipartisan, cross-agency, public-private effort spearheaded by the Governor-appointed Transformation Working Group (TWG) (Appendix A) and funded by the federal Substance Abuse Mental Health Services Administration (SAMHSA), Missouri has created **its first Comprehensive Plan for Mental Health to address the mental health needs of Missourians across the lifespan.** The President's New Freedom Commission (NFC) on Mental Health provided the foundation for this transformation when issuing their final report in July 2003 (http://www.mentalhealthcommission.gov/reports/reports.htm). Established through Executive Orders 06-39 and 07-15, the TWG is comprised of consumer and family leaders and public leaders from the executive and judicial branches (Appendix A). The TWG Co-Chairs and principle staff are based in the Director's Office of the Department of Mental Health (DMH) to lead and staff the planning process in partnership with other state agencies involved with mental health services.

Missouri's progress in system transformation and cross-agency collaboration was a key factor in SAMHSA's award—specifically, the creation and initial implementation of the Comprehensive Mental Health Plan and System for Children mandated through Senate Bill 1003. Missouri's Transformation Initiative builds upon this work and includes a structure to create a long-needed Comprehensive Mental Health Plan to address Missourians' mental health needs across the lifespan.

Scope of Plan

Transforming an entire system is a tremendous undertaking. Compiling, creating and conveying a transformation action plan in the most simplistic terms is exceptionally challenging. **Every attempt has been made to be inclusive and comprehensive of all persons, groups, systems and stakeholders and their unique opinions and views while being concise and precise in writing the plan.** In Missouri, DMH is the public mental health authority. However multiple federal, state, local and private entities either provide or fund mental health services in Missouri. Therefore, **this plan sets forth a shared vision and strategic direction that transcends traditional state, local, public and private boundaries.** It provides a roadmap for all mental health stakeholders, incorporating existing initiatives and expanding into content areas as needed to achieve a transformed system.

- From a population perspective, the plan addresses mental health issues important to all Missourians. Specifically it addresses the **needs of persons either at risk of developing, or having mental illnesses, substance use and addictive disorders and mental retardation/developmental disabilities.** In fact, Missouri is the only state to incorporate these three target populations into an overall Mental Health Transformation Initiative.

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- **A life-span perspective was adopted.** Every effort has been made to consider the needs of children, adolescents, adults, and the elderly. While these age groups may not be specifically cited in each example, the intent to cover the full lifespan is implied throughout the document.
- **Planning was also organized to incorporate issues specific to culture and geography**. Missouri is a culturally and geographically rich state. There is no such thing as a "one size fits all" mental health system to address the diversity of the citizens and regions. Therefore, designing local infrastructure to meet the specific mental health needs of area populations is critical. Cultural and ethnic groups reside throughout the state and include but are not limited to persons who are African American, Hispanic, Deaf and Hearing Impaired, Bosnian, Russian, Asian, refugees and immigrants from war-torn countries, etc. Bordered by eight states and the Mississippi River, Missouri has the urban centers of St. Louis and Kansas City on her east and west borders, respectively; mid-sized cities, small towns and rural outposts throughout the state; thousands of acres of farmland, the rambling Ozark Mountains, and the extensive Mark Twain National Forest. To address this geographic spectrum, **the Transformation Initiative has identified four geographic categories: Rural-rural which are the most remote and isolated locations, rural, suburban, and urban.**

The Need to Transform

A Serious Public Health Crisis

Of the approximate 5.8 million people who live in Missouri, it is estimated that 10.5% have a serious mental illness, 11% are alcohol dependent, 3% are drug dependent and 1.5% experience mental retardation or a significant developmental disability. (NARI, 2008) Given this prevalence, it is not surprising that there is an enormous emotional and financial burden on individuals, their families and Missouri as a whole. Unfortunately, **the impact of these problems on health and productivity is substantial and has long been underestimated.** The landmark *Global Burden of Disease* study (World Health Organization (WHO) 1990) and project (WHO 2000) found that the impact of mental and behavioral disorders on the health and productivity in the United States is vast. This data revealed that **mental illness alone, including suicide, accounts for over 15% of the burden of disease in established market economies such as the United States - *more than the disease burden caused by all cancers.***

This new knowledge brings urgency to the issue of mental health. Historically, mental health problems have not received the level of attention of other diseases and disabilities with a similar public health impact. In addition, his 1999 report on Mental Health, **the Surgeon General found that despite the numerous scientific advances and treatment options that exist nearly half of all Americans who have a mental disorder do not seek treatment.** Many barriers exist. Foremost among these is the pervasive stigma associated with these problems.

The health of Missouri citizens and the economy depend on the ability to focus efforts to reduce the burden of disease associated with mental health conditions. In the absence of concerted efforts to prevent, diagnose, and better manage and treat these conditions, Missouri will needlessly bear higher socioeconomic costs over time. Many of these costs can be avoided through prevention, early intervention and effective treatment and supportive services.

A Complex and Fragmented System

"Every system is perfectly designed to achieve exactly the results it gets"

Berwick, 2003

Even when people do seek care, there are significant barriers to accessing the care that is needed. The traditional segregation of the mental health system from the overall health system contributes greatly to the public health crisis. In its interim report to the President, the New Freedom Commission declared "…**the**

mental health service delivery system is fragmented and in disarray…leading to unnecessary and costly disability, homelessness, school failure and incarceration." Even the private sector is not immune to this problem. Despite important progress, the National Business Group on Health identified that within the private employer market, standardized and integrated programs addressing the delivery of mental healthcare services remain rare and benefits are fragmented, uncoordinated, duplicative, and uneven in terms of access and quality. *("Employer's Guide to Behavioral Health Services"* December 2005)

The system complexity in Missouri is illustrated by the number of providers, key stakeholders, and special issues. Grasping the full scope of Missouri's mental health system begins with an understanding of the Department of Mental Health. DMH is Missouri's public mental health authority and served approximately 158,000 people statewide last year in its three divisions. (Note: the preceding number is a duplicated count because individuals may be served by one or more divisions.)

- 53,000 Division of Alcohol and Drug Abuse (ADA)
- 75,000 Division of Comprehensive Psychiatric Services (CPS)
- 30,000 Division of Mental Retardation and Developmental Disabilities (MRDD)

Despite these large numbers, state prevalence estimates indicate that **DMH meets the needs of only 8% of Missouri's population with substance abuse disorders (based on adding alcohol and drug dependency prevalence rates together), 12% of persons with mental illness, and 35% of persons with mental retardation/developmental disabilities.** (NARI 2008) Accurately assessing unmet (or under met) need is extremely difficult given the complex and fragmented system of care.

There are seven organizations at the Federal level that fund mental health services including the departments of: 1) Health and Human Services; 2) Education; 3) Labor; 4) Agriculture 5) Veterans Affairs 6) Justice and 7) Housing and Urban Development. **Seven State agencies are involved** including the departments of 1) Mental Health (DMH); 2) Corrections (DOC); 3) Elementary and Secondary (DESE); 4) Social Services (DSS); 5) Health and Senior Services (DHSS); 6) Public Safety (DPS) ; and 7) the Office of State Court Administrators (OSCA).

At the local level, there are public entities (County mental health boards, courts, etc.) and private entities (employers, private foundations, United Way, etc). There are thousands of providers with a vast and wide array of educational backgrounds and expertise. **Services are provided across 114 counties and 541 school districts**. Organizations have separate and overlapping service areas, different criteria and standards for care and conflicting policy and reimbursement mechanisms. There are varied and often competing interests across stakeholders, and the scarcity of resources challenges stakeholders with a particular passion or interest to adopt a broad view of the issues. As a result, care is organizationally fragmented, creating significant and unnecessary barriers to access.

Toward a Public Health Approach

Moving Missouri toward a public health approach is the overarching theme of the Transformation Initiative. Given the sheer magnitude; multiple causes; widespread stigma and discrimination; and the significant treatment gaps that exist around the world, the World Health Organization (WHO), recommended a public health approach as the most appropriate response to reduce the global burden of disease and disability associated with mental and behavioral disorders (GBD WHO 2000). Echoed in the 1999 United States Surgeon General's Report on Mental Health and encompassed by Missouri's Comprehensive Mental Health Plan for Children**, this approach serves as a solid foundation for creating Missouri's first Comprehensive Mental Health Plan to meet the mental health needs of Missourians across the lifespan.**

The public health model provides a continuum of services focusing on an entire population rather than individuals or their separate illnesses and disabilities. The continuum offers services from prevention to treatment and supports. It starts with an assessment of mental health needs, continues through population-

based research on addressing those needs, and identifies policies and practices that promote wellness. Collective action and cooperative efforts among diverse agencies is required. Individuals, communities, organizations and leaders must collaborate to promote mental health. Mental health must be integrated with the overall health system *and* considered essential to the overall well-being of Missourians. Missouri emphatically agrees with the NFC that mental health is essential to overall health.

Missouri Transformation—"Creating Communities of Hope"

When the world says, "Give up,
Hope whispers, "Try it one more time."
~Author Unknown

While there remains much to be learned, the emerging scientific evidence is clear: the knowledge and power exist to significantly improve mental health and reduce the burden of disease and disability throughout the nation and in Missouri. This knowledge serves as grounds for a message of hope. Therefore, **Missouri's vision begins with "Hope."** Hope provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. Although hope is personal and internalized, it can be greatly enhanced by interpersonal relationships with family, friends, neighbors, providers, teachers, employers and others in the community. Thus, Missouri's vision also embraces the **"Community" which provides fuel for hope**. A community approach is essential to the public health model. Only the collective will of communities can promote mental health and provide the opportunities and supports necessary for everyone to live, learn, work and participate fully in them. **Therefore, transforming Missouri's mental health system equates quite simply to "Creating Communities of Hope."**

From the beginning of Missouri's Transformation planning process, the public has shared their personal vision of a Community of Hope. The range of answers is enlightening and powerful:

- "People are viewed as part of the community and not as an outcast or someone who is not capable of living a productive life if given or provided needed services."
- **"**People are recognized as individuals with strengths and abilities first. Professionals listen (really listen) and stop trying to fit people with needs into boxes."
- **"**Government supports treatment that works**."**

From complex to simple, urban to rural, across mental health population groups and state agencies, these personal Community of Hope visions provide an important foundation for Missouri's transformed mental health system. Missouri's vision serves as a ***"Call to Action"*** to reduce the burden of disability for the estimated **1.3 million Missourians with mental illnesses, addiction disorders and developmental disabilities** and those at risk of developing them across the state.

A Thousand Voices—All Walks of Life

"Never tell people how to do things. Tell them what to do and they will surprise you with their ingenuity." - General George Smith Patton, Jr.

To address the conversion of an entire system takes buy-in from consumers, providers, employees, educators, citizens and leaders from across the system. **The process is as important as the product.** As one of nine states funded to do so, Missouri built upon the NFC guidance and brought together key leaders and stakeholders from across the state to create a shared vision and framework to truly transform the mental health system. The TWG sought input from all sides of the mental health system so they recruited leaders and experts from all sectors to provide their views and concerns in shaping this effort.

- The TWG chartered six workgroups around the goals of the New Freedom Commission report. **More than 240 citizens with specialized expertise from diverse backgrounds volunteered their time and expertise to participate in these workgroups.** (Appendix B)

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- The Missouri Institute of Mental Health (MIMH) conducted a **Needs Assessment and Inventory of Resources (NARI).** MIMH researchers gathered information from a variety of individuals and organizations involved in Missouri's mental health care system including consumers, provider agencies, state agency personnel, other professionals and the general population. Numerous focus groups, key informant interviews and surveys were conducted as part of the needs assessment. **A special effort was made to engage persons whose voices were underrepresented through focus group and key informant interviews.** The NARI serves as a companion document to this plan. MIMH will distribute this document and it is also posted on the Transformation website. http://www.dmh.mo.gov/transformation/transformation.htm
- **Hundreds of Missourians attended 14 public meetings** held across the state to discuss the initial recommendations.

Representation and input was gathered from key stakeholders throughout the planning stages. **Although every attempt was made to be inclusive of all views, it is acknowledged that there may be perceived gaps in addressing specific interests.**

Consumers and Families Lead the Way

Consumer and family input and leadership is at the forefront of this initiative. Consumers and families are the bridge between the mental health system as it exists now and the system as it should be. It is their life and hope for the future at stake. Therefore, their needs, wants, and goals should guide the decision-making process at all system levels. Creating a system that meets their needs fully is the **reason** for undertaking the difficult and necessary work ahead.

TWG members, mental health advisory councils and advocacy groups, elected officials and mental health system representatives nominated consumer and family members to serve on workgroups. Specific consumer expertise is ensured through contracted staff to provide family and peer leadership and support in planning, implementation and evaluation activities. In addition, there is dedicated staff leadership support from the DMH Office of Consumer Safety. A Consumer and Family Leadership Training was held prior to the commencement of the Transformation content workgroups. http://www.dmh.mo.gov/transformation/FINALCFYLeadershiptrainingNov2007.pdf Consumer and family leaders were actively involved in all content workgroups and met following the meetings to discuss workgroup actions, their impact or concerns with the process and related issues. Issues were then communicated back to workgroups to address. Support was available between meetings as needed and requested. MIMH surveyed these leaders as part of the overall Transformation evaluation.

Addressing Complexity

"The problem is that most people will only focus on doing more of the same thing or just try to do the same thing better. They won't think of a new way to do it." Consumer Leader

Development of a "new and better" comprehensive statewide mental health system requires changes in state policies, financing mechanisms, training and other support structures; changes at the state and local level to plan, implement, manage and evaluate the system; and changes at the service delivery level to ensure quality prevention and treatment services and supports. A major challenge facing the TWG involved how to ensure work group participants obtained and used a global perspective to assess Missouri's existing mental health system and use this systems view to guide the Mental Health Transformation efforts. Although participants in each workgroup were familiar with some aspect of mental health, most had only a limited view of the whole system. This was seen as both a consequence of system fragmentation and a barrier to change. Additionally, the TWG wanted to distinguish this planning effort from earlier efforts to re-engineer or change mental health care. They also wanted a way to evaluate recommendations and identify priorities from the perspective of a broad population-based viewpoint. They took several steps to address this:

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- **A logic model was developed** (Appendix E) to serve as a broad outline and guide. In the model, various inputs (resources, technical assistance, and levers of change) were identified along with actions that influence and support the desired objectives and strategic goals.
- Not only did the Missouri Institute of Mental Health (MIMH) staff conduct the needs assessment and inventory of resources as a companion piece to the Comprehensive Plan, but they also participated in the workgroups from day one. They observed the meeting process as part of their evaluation plus gathered findings and data that emerged during the assessment process. MIMH **developed a toolkit to provide relevant data to workgroup members** as they developed and analyzed various strategies and actions.
- All **workgroup meetings were facilitated by skilled and objective facilitators** through the Change and Innovation Agency using a variety of methods to ensure that the various aspects of the system were addressed, common themes and potential overlap across workgroups identified and discussed, and diverse perspectives incorporated.
- A consultant with expertise in "systems modeling" assisted the workgroups during their initial meetings with **a group model building (causal mapping) process** based on principles of system dynamics (Appendix C). This model was then integrated across groups and updated as objectives, strategies and actions were identified during the planning process. The model was used to help the TWG and workgroup participants see the larger whole, identify potential leverage points for change, identify potential threats to the implementation and sustainability of recommendations and prioritize actions.

A Common Agenda

"Alone we can do so little; together we can do so much." -Helen Keller

The diverse stakeholders involved in this planning effort have not historically spoken with one voice. As recommendations emerged there often was disagreement among and between consumers, families, providers, educators, policy makers and others. But as the discussions progressed and differences in language, assumptions and intent were explored and made transparent, it became clear that there are more commonalities than differences regarding mental health issues across the various interest groups. It also became abundantly clear that the people across these diverse populations and sectors have much to learn from each other and much to be gained by working together on a common agenda.

Missouri Transformation- Six Strategic Themes

The common agenda that emerged to achieve the shared vision and move Missouri toward a public health approach resulted in six strategic themes. The Strategic Themes are outlined in Table 1 on the following page. Symbols represent these themes which emerged from the planning and public input process. The strategic themes are explained in Part 1 of the plan according to 1) What is the issue; 2) Where do we need to go in Missouri and 3) How will we know we are successful?

Goals and Objectives

Table 2 summarizes the Missouri's Transformation Goals and Objectives. These goals and objectives, like the Strategic Themes, are shared across stakeholders. All are based upon the New Freedom Commission findings and refined for Missouri via the planning and public input process. The Strategic Theme symbols are used in Table 1 to illustrate the relationship and alignment between those themes and the Transformation Goals and Objectives. See Part 2 of the plan for full details.

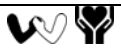
TABLE 1: MISSOURI MENTAL HEALTH TRANSFORMATION STRATEGIC THEMES

"Creating Communities of Hope"

Moving Missouri Toward a Public Health Approach

MOVE FROM:		MOVE TO:
CULTURE OF CRISIS/ RISK OF HARM	→	CULTURE OF HOPE/ FIRST…"DO NO HARM" 
"NO WHERE TO GO"	→	EASY, EARLY AND EQUAL ACCESS 
DISABILITY FOCUS	→	WELLNESS FOCUS WITH PREVENTION AND EARLY INTERVENTION 
BUREAUCRACY/ PROVIDER DRIVEN CARE	→	CONSUMER DIRECTION AND EMPOWERMENT 
"POCKETS" OF EXCELLENCE	→	UNIVERSAL BEST PRACTICES 
FRAGMENTED & CENTRALIZED SYSTEM	→	SHARED OWNERSHIP & INVESTMENT (STATE-LOCAL, PUBLIC-PRIVATE) 

TABLE 2: MISSOURI COMPREHENSIVE MENTAL HEALTH PLAN GOALS AND OBJECTIVES

GOAL 1: MISSOURIANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH	**OBJECTIVE 1.1:**	INCREASE PUBLIC UNDERSTANDING AND REDUCE STIGMA OF MENTAL ILLNESS, SUBSTANCE ADDICTIONS AND DEVELOPMENTAL DISABILITIES.	
	OBJECTIVE 1.2:	DEVELOP AND IMPLEMENT A STATEWIDE PREVENTION FRAMEWORK THAT ADDRESSES COMMON RISK AND PROTECTIVE FACTORS.	
	OBJECTIVE 1.3:	INTEGRATE PUBLIC, PRIMARY AND MENTAL HEALTH CARE PRACTICES.	
GOAL 2: MISSOURI'S MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN	**OBJECTIVE 2.1:**	INCREASE CONSUMER DECISION-MAKING AND SELF-DIRECTION OF INDIVIDUALIZED PLANS OF CARE.	
	OBJECTIVE 2.2:	EXPAND AND INTEGRATE PEER AND FAMILY SUPPORT SERVICES INTO THE SYSTEM OF CARE.	
	OBJECTIVE 2.3:	CREATE A CULTURE OF RESPECT, DIGNITY & WELLNESS AS THE MILIEU IN WHICH ALL MENTAL HEALTH SERVICES ARE PROVIDED.	
	OBJECTIVE 2.4	INCREASE THE NUMBER OF CONSUMERS FULLY PARTICIPATING IN THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF THE SYSTEM.	
GOAL 3: MENTAL HEALTH DISPARITIES ARE ELIMINATED IN MISSOURI	**OBJECTIVE 3.1:**	IMPROVE ACCESS TO QUALITY CARE IN RURAL AND GEOGRAPHICALLY REMOTE AREAS.	
	OBJECTIVE 3.2:	IMPROVE ACCESS TO CULTURALLY COMPETENT CARE	
	OBJECTIVE 3.3:	INCREASE CONSUMER ACCESS TO PROGRESSIVE EMPLOYMENT OPPORTUNITIES IN INTEGRATED COMMUNITY SETTINGS.	
	OBJECTIVE 3.4:	INCREASE CONSUMER ACCESS TO SAFE AND AFFORDABLE HOUSING IN INTEGRATED COMMUNITY SETTINGS.	
GOAL 4: EARLY MENTAL HEALTH SCREENING, ASSESSMENT AND REFERRAL TO SERVICES ARE COMMON PRACTICE IN MISSOURI	**OBJECTIVE 4.1:**	PROVIDE TIMELY OUTREACH, SCREENING AND REFERRAL TO CARE THAT IS AGE AND CULTURALLY APPROPRIATE.	
	OBJECTIVE 4.2:	PROVIDE MENTAL HEALTH CONSULTATION AND SERVICES IN EARLY CHILDHOOD AND SCHOOL SETTINGS.	
	OBJECTIVE 4.3:	EXPAND COMMUNITY CAPACITY TO REDUCE AVOIDABLE USE OF EMERGENCY ROOMS, HOSPITALS AND OTHER INSTITUTIONAL CARE.	
GOAL 5: EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND RESEARCH IS ACCELERATED	**OBJECTIVE 5.1:**	DEVELOP THE MENTAL HEALTH WORKFORCE	
	OBJECTIVE 5.2:	EXPAND EVIDENCE-BASED PRACTICES (EBPS) ACROSS THE STATE.	
	OBJECTIVE 5.3:	APPLY RESEARCH EVIDENCE MORE QUICKLY AND INVEST IN RESEARCH FOR NEW AND PROMISING PRACTICES.	
	OBJECTIVE 5.4:	DEVELOP A COMPREHENSIVE QUALITY MANAGEMENT SYSTEM.	
GOAL 6: MISSOURI COMMUNITIES ARE PROFICIENT IN MEETING LOCAL MENTAL HEALTH NEEDS	**OBJECTIVE 6.1:**	CREATE CONSISTENT & FLEXIBLE POLICY/PRACTICES ACROSS STATE AGENCIES THAT ARE INFORMED BY CONSUMERS & LOCAL NEEDS.	
	OBJECTIVE 6.2:	CREATE AND/OR EXPAND LOCAL PUBLIC-PRIVATE COLLABORATIVES TO IMPROVE SERVICE ACCESS, CAPACITY AND INTEGRATION.	
	OBJECTIVE 6.3:	EXPAND THE ROLE AND CAPACITY OF COMMUNITIES TO IDENTIFY THEIR NEEDS, PROMOTE MENTAL HEALTH & CREATE OPPORTUNITIES FOR CONSUMER INCLUSION.	

Priority Actions

The TWG priorities were shaped throughout the planning and public input process. Part 3 of this plan provides a detailed review of the 2008 priority actions. Although numerous actions have been identified to address the multiple goals and objectives, the TWG prioritized actions to accomplish the following:

Build the Foundation for Hope

- Reduce stigma and increase public understanding
- Promote wellness and integrate mental health and public/primary health practices to address the holistic needs of Missourians.
- Establish a system-wide individual planning process that emphasizes the consumers and families as decision-makers.
- Expand and integrate peer and family support services into the mental health system.
- Increase the voice of consumers and families in mental health policy decisions and actively develop and support new leaders.

Balanced Capacity Building

- Identify the true level of unmet need in the state and build local capacity for easy, early and equal access to care. This includes the provision of equitable mental health benefits and equal access to culturally appropriate services.
- Implement a balanced “portfolio” approach to incrementally expand evidence-based prevention, treatment and support services, apply research evidence more quickly and invest in research for new and promising practices.
- Increase the capacity of local communities to assess and meet local needs and support full community inclusion. This includes coordinating and integrating local services and expanding educational, employment and housing opportunities in integrated settings.
- Establish an enduring structure to integrate & coordinate mental health policy and administrative practices across state departments/agencies to meet the needs of Missourians.

Sustaining Momentum and Change

Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.

Margaret Mead

True transformation requires changing the underlying infrastructure and the culture of the mental health system. Responsibility for mental health treatment service will never be the sole domain of a single entity. Public mental health must form partnerships with local government, communities, the private sector and ultimately secure ownership by Missourians statewide. This plan provides the initial roadmap for such action.

How to Read this Document

Key Concepts

Every effort has been made to ensure this plan reflects the input of hundreds of Missourians who volunteered to create this comprehensive vision of Missouri's mental health future. It is challenging to capture the passion and commitment of these leaders and key stakeholders involved in transforming Missouri's mental health system within a document designed as a roadmap for action. Since this document is compiled from several sources and edited into one voice, it may not be perfect, but it is certainly heartfelt. While attempting to be 100% current in the content provided, it is acknowledged that once published, this document will be outdated due to the inevitable changes in the state and federal economy, advances in science and technology, political climate, and other realities that impact Missouri's mental health system. What is provided is the snapshot of Missouri as of March 2008. Key sections such as Part 4, Action Plan will be updated annually and posted online to reflect current priorities. As the reader explores the content, please keep the following in mind:

- It is a challenge to be broad and inclusive while being concise and precise in summarizing hours of research and discussion into a Comprehensive Plan. Missouri is a complex and diverse community of people who identify with one or more special populations or interests. Throughout the planning process, the goal has been to be inclusive, not exclusive and to identify and address gaps.

- Terminology is a challenge so a glossary of terms and acronyms is provided as Appendix D. The glossary has terms and acronyms from this Comprehensive Plan and the Needs Assessment and Resource Inventory (NARI), a companion piece that is a separate publication. Not all terms are defined so only the acronym is provided. Where applicable, the source of the definition is provided. There continues to remain a lack of consensus on terms that are broadly applicable and acceptable to all persons in the field. The plan uses "people first" language as a rule of thumb. However, it is recognized that many of the terms used within this document are imprecise and imperfect. Two terminology examples worth noting include:

    - The plan uses the terms "mental disorders" or "mental and behavioral disorders" interchangeably to refer to developmental disabilities, mental illnesses, emotional disorders and substance and other addiction disorders.

    - The term "consumer" in this document refers to persons of all ages and population groups as well as families/guardians. In addition, it is inclusive to persons accessing services of any of the three Department of Mental Health (DMH) divisions [Alcohol and Drug Abuse (ADA), Comprehensive Psychiatric Services (CPS) and Mental Retardation and Developmental Disabilities (MRDD)] as well as individuals receiving mental health care from other state agencies or service providers.

  In addition, there is a link to the Glossary at the beginning of each section of the electronic version of the plan. For those reading a hard copy of this document, the Glossary appears at the end of the publication.

- Symbols are used to simplify the relationship between the six Strategic Themes that emerged from the planning and public input process and their alignment with the Transformation Goals and Objectives. The Strategic Themes are outlined in Table 1 and the Goals and Objectives can be found in Table 2 in the executive Summary.

- Missouri's vision to create "Communities of Hope" is at the forefront of the Missouri Transformation Initiative. Therefore, Community of Hope quotes are used in Part 3: Goals & Objectives of the plan to illustrate how the Goals and Objectives can make a difference.

How to Read this Document

Plan Organization and Format

Missouri's plan is organized into the following sections. As relevant, sections will be updated throughout implementation to ensure timely information is captured and shared.

- **Executive Summary**. This section provides highlights of the overall plan.
- **How to Read this Document**. Tips to guide the reader through the comprehensive plan which attempts to cover a complex topic in a direct and concrete format.
- **Part 1: Vision & Strategic Direction.** Provides an overview of the public health approach and exploration of each of the six strategic themes. The strategic themes are addressed according to 1) What is the issue; 2) Where do we need to go in Missouri and 3) How will we know we are successful?
- **Part 2: Goals & Objectives**. Missouri's Six Goals are aligned with the President's New Freedom Commission findings and have one or more objectives. Each objective provides Core Strategies. The goals, objectives and strategies are compiled from the recommendations and input of the content workgroups, TWG and public meetings.
- **Part 3: Action Plan**. Presents the 2008 priority actions and the Transformation objectives addressed by each action; the responsible party; Accountability, Capacity, and Effectiveness or ACE GOALS the Government Performance Act of 1993 or GPRA measures (both are mandated by SAMHSA as part of the evaluation of this project); complexity of implementation; timeline, and the target populations and age groups addressed by the action.
- **Part 4: Governance.** Identifies key leadership entities, provides a table of the Transformation Governance Structure and addresses sustainability.
- **References and Links**. Research cited within the plan is listed here. Links are provided to relevant reports, presentations and websites.
- **Appendices.** Additional material mentioned within the plan as follows:

Appendix A:	Transformation Working Group Membership Roster
Appendix B:	Transformation Workgroups and Membership
Appendix C:	Causal Mapping
Appendix D:	Glossary of Terms and Acronyms
Appendix E:	Logic Model

Needs Assessment and Resource Inventory

As part of the implementation of the Comprehensive Plan, the Missouri Institute of Mental Health (MIMH) created the NARI to be used as a companion document. MIMH researchers gathered information from a variety of individuals and organizations to identify the greatest mental health care needs and what changes could be made to the mental health care system to better meet those needs. In addition to the needs assessment, MIMH compiled an inventory of current state-level mental health care available to meet the needs of Missourians with mental illness. The NARI identifies resources from state departments involved in the provision of mental health care. MIMH will distribute this document and it is also posted on the Transformation website. http://www.dmh.mo.gov/transformation/transformation.htm In subsequent years, a NARI supplemental report with a more in-depth review of mental health needs and existing resources will be provided.

Introduction: The Impact of Mental Health Problems on Society

Of the approximate 5.8 million people who live in Missouri, it is estimated that **10.5% suffer from either serious psychological or emotional distress, 11% are alcohol dependent, 3% are drug dependent and 1.5% experience mental retardation or a developmental disability (NARI 2008).** Given this prevalence, it is not surprising that there is an enormous emotional and financial burden on individuals, their families and society as a whole. The economic impact of these problems affect personal income - the ability of ill persons, and often their caregivers - to work, productivity in the workplace, and contributions to the national economy. Unfortunately, **the impact of these problems on health and productivity is substantial and has long been underestimated.** In the landmark *Global Burden of Disease* study and project, the World Health Organization (WHO GBD 1990; 2000) developed a single measure called Disability Adjusted Life Years (DALYs) to allow for a comparison of the burden of disease across many different health conditions. DALYs measure lost years of healthy life regardless of whether the years were lost to premature death or disability**.** The study found that the impact of mental disorders on health and productivity in the United States is vast. This data revealed that **mental illness, including suicide, accounts for over 15% of the burden of disease in established market economies such as the United States. This is more than the disease burden caused by all cancers.** For society, the cost of untreated mental illness is more than 100 billion dollars each year in the United States alone. Moreover, there is strong evidence that mental disorders impose a range of consequences on the course and outcome of co-morbid chronic conditions, such as cancer, heart disease, diabetes and HIV/AIDS. http://www.who.int/mental_health/policy/en/Country%20activities%20table%20of%20contents.pdf

Alcohol use accounts for 4.7% and drug use 1.5% of the burden of disease. While estimates are not available for the full range of developmental disabilities or their risk factors, attempts have been made to estimate the burden associated with specific causes. For example, it is estimated that nearly 1% percent of the global burden of disease is due to a relatively minor form of Learning and Developmental Disabilities, namely, mild mental retardation (MR) caused by lead ingestion from environmental sources (Fewtrell and others 2004). Since only a small fraction—probably much less than 10 % —of learning and developmental disabilities worldwide can be attributed to lead-induced mild MR, this estimate suggests that ***learning and developmental disabilities as a whole must account for a large proportion, perhaps more than 10% of the global burden of disease.*** (Disease Control Priorities Related to Mental, Neurological, Developmental and Substance Abuse Disorders, WHO 2006)

Reducing the avoidable personal and economic costs associated with these conditions is central to meeting the twin challenges of promoting affordable health care and fostering continued economic growth. The health of Missouri citizens and the economy depend on the ability to focus efforts to reduce the burden of disease. In the absence of concerted efforts to prevent, diagnose, and better manage and treat chronic disease, the state will needlessly bear higher socioeconomic costs over time. Many of these costs can be avoided through prevention, early intervention and effective treatment and supportive services. For example, although the average annual costs, including medical, pharmaceutical and disability costs, for employees with depression may be 4.2 times higher than those incurred by a typical beneficiary, the cost of treatment is often completely offset by a reduction in the number of days of absenteeism and productivity lost while at work.
http://www.who.int/mental_health/media/investing_mnh.pdf

Part 1: Vision and Strategic Direction

Missouri's Vision of a Transformed Mental Health System

VISION:
Communities of Hope
throughout Missouri support a system of care where promoting mental health and preventing disabilities is common practice,
and
everyone has access to treatment and supports essential for living, learning, working and participating fully in the community.

Missouri's vision of a transformed mental health system is a **"Call to Action"** to reduce the burden of disability for the estimated **1.3 million Missourians with mental illnesses, addiction disorders and developmental disabilities** and those at risk of developing them across the state. **It is first and foremost about "Hope."** Hope provides the essential and motivating message of a better future— that people can and do overcome the barriers and obstacles that confront them. It is now known that biological, psychological and social factors intertwine to impact the development and progression of mental and behavioral disorders. While there remains much to be learned, the emerging scientific evidence is clear: the knowledge and power exist to significantly improve mental health and reduce the burden of disease and disability associated with these disorders throughout the state. This knowledge serves as grounds for a message of hope. Hope is the catalyst for both personal and system transformation. Although hope is personal and internalized, it can be greatly enhanced by interpersonal relationships with family, friends, neighbors, providers, teachers, employers and others in the community. Thus, Missouri's vision also embraces the **"community", which provides fuel for hope**. Only the collective will of communities can promote mental health and provide the opportunities and supports necessary for everyone to live, learn, work and participate fully in them. **Therefore, transforming Missouri's mental health system equates quite simply to "Creating Communities of Hope."**

From the beginning of Missouri's Transformation planning process, the public has shared their personal visions of a Community of Hope. To date, hundreds of comments have been submitted, reviewed, and used to inform the planning and implementation strategies. The range of answers is enlightening and powerful:

- "People are viewed as part of the community and not as an outcast or someone who is not capable of living a productive life if given or provided needed services."
- **"**People are recognized as individuals with strengths and abilities first. Professionals listen (really listen) and stop trying to fit people with needs into boxes."
- "The public is educated about mental illness and there is no stigma. People see me as having a purpose in life, intelligent enough to work, capable of responsibility. "
- **"**Government supports treatment that works**."**

From complex to simple, urban to rural, across mental health population groups and state agencies, these personal Community of Hope visions provide an important foundation for Missouri's transformed mental health system.

Toward a Public Health Approach

Given the sheer magnitude; multiple causes; widespread stigma and discrimination; and the significant treatment gaps that exist around the world, the World Health Organization (WHO), recommends a public health approach as the most appropriate response to reduce the global burden of disease and disability associated with mental and behavioral disorders. Echoed in the United States Surgeon General's Report on Mental Health and encompassed by Missouri's Comprehensive Mental Health Plan for

Children, this approach serves as a solid foundation for creating Missouri's first Comprehensive Mental Health Plan to meet the mental health needs of Missourians across the lifespan.

The public health model provides a continuum of services focusing on an entire population rather than individuals or their separate illnesses and disabilities. The continuum offers services from prevention to treatment and supports. It starts with an assessment of mental health needs, continues through population-based research on addressing those needs, and identifies policies and practices that promote wellness. Collective action and cooperative efforts among diverse agencies is required. Individuals, communities, organizations and leaders must collaborate to promote mental health. The public health model uses the community to establish a comprehensive mental health services system. Mental health is integrated with the overall health system *and* considered essential to the overall well-being of Missourians.

According to the Centers for Disease Control (CDC), there are 10 Essential Public Health Services to be included at the local, state and governance level. (http://www.cdc.gov/od/ocphp/nphpsp/EssentialPHServices.htm) Table 3 adapts these to Missouri's mental health system and outlines the essential services.

From a public health perspective, the WHO found that there is much to be accomplished in reducing the burden of mental disorders:

- Formulating policies designed to improve the mental health of populations;
- Assuring universal access to appropriate and cost-effective services, including mental health promotion and prevention services;
- Ensuring adequate care and protection of human rights for institutionalized persons with most severe mental disorders;
- Assessment and monitoring of the mental health of communities, including vulnerable populations such as children, women and the elderly;
- Promoting healthy lifestyles and reducing risk factors for mental and behavioral disorders, such as unstable family environments, abuse and civil unrest;
- Supporting stable family life, social cohesion and human development;
- Enhancing research into the causes of mental and behavioral disorders, the development of effective treatments, and the monitoring and evaluation of mental health systems.

Table 3:
10 Essential Public Health Services (*adapted from the CDC to emphasize mental health):*

Essential Service #1: Monitor Health Status to Identify Community *Mental* Health Problems

Essential Service #2: Diagnose and Investigate *Mental* Health Problems and *Mental* Health Hazards in the Community

Essential Service #3: Inform, Educate and Empower People about *Mental* Health Issues

Essential Service #4: Mobilize Community Partnerships to Identify and Solve *Mental* Health Problems

Essential Service #5: Develop Policies and Plans that Support Individual and Community *Mental* Health Efforts

Essential Service #6: Enforce Laws and Regulations that Protect *Mental* Health and Ensure Safety

Essential Service #7: Link People to Needed Personal *Mental* Health Services and Assure the Provision of *Mental* Health Care when Otherwise Unavailable

Essential Service #8: Assure a Competent Public and Personal *Mental* Health Care Workforce

Essential Service #9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based *Mental* Health Services

Essential Service #10: Research for New Insights and Innovative Solutions to *Mental* Health Problems

Using a public health approach can also overcome the divisions between mental health and other health care where professionals fail to consider the areas of health outside their "narrowly focused"

responsibility. SAMHSA administrator Terry Cline, Ph.D. endorses this public health approach. "If you have a relationship with a person and are already providing care, it's a great opportunity to expand care elsewhere," Cline said about the comprehensive approach he advocates. "We've seen it work for other illness categories, and we know it works with mental illness." (Psychiatric News July 20, 2007 Volume 42, Number 14, page 14)

To create "Communities of Hope" and move the state toward a public health approach, Missouri must fundamentally transform the way the entire system thinks and operates today. Table 1 depicts the overarching strategic themes that emerged through the planning and public input process to transform the mental health system in Missouri. The following pages explore each theme.

TABLE 1: MISSOURI MENTAL HEALTH TRANSFORMATION STRATEGIC THEMES

"Creating Communities of Hope"

Moving Missouri Toward a Public Health Approach

MOVE FROM:		MOVE TO:
CULTURE OF CRISIS/ RISK OF HARM	→	CULTURE OF HOPE/ FIRST…"DO NO HARM"
"NO WHERE TO GO"	→	EASY, EARLY AND EQUAL ACCESS
DISABILITY FOCUS	→	WELLNESS FOCUS WITH PREVENTION AND EARLY INTERVENTION
BUREAUCRACY/ PROVIDER DRIVEN CARE	→	CONSUMER DIRECTION AND EMPOWERMENT
"POCKETS" OF EXCELLENCE	→	UNIVERSAL BEST PRACTICES
FRAGMENTED & CENTRALIZED SYSTEM	→	SHARED OWNERSHIP & INVESTMENT (STATE-LOCAL, PUBLIC-PRIVATE)

TRANSFORMING FROM A CULTURE OF CRISIS TO A CULTURE OF HOPE

What is the Issue?

Missouri's mental health system should instill hope in those seeking care. Inspiration comes from the medical field where the care philosophy often credited to Hypocrites has been passed down for centuries to physicians: **"As to diseases, make a habit of two things -- to help, or at least, to do no harm."** Unfortunately**, many Missourians have had painful experiences with the mental health system**. Such experiences often cause harm, hardship, and the erosion of trust and hope. The Needs Assessment and Resource Inventory (NARI) identified key safety issues (Table 4). For example, although many medical errors are preventable, the Institute of Medicine report, *"To Err is Human, Building a Safer Health System"* identified that deaths attributed to preventable medical errors in hospitals exceed those attributable to threats from motor-vehicle wrecks, breast cancer, and AIDS. One of the report's main conclusions is that **"the majority of medical errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them.** Thus mistakes can best be prevented by designing the health system at all levels to make it safer, to make it harder for people to do something wrong, and easier for them to do it right."

It is not acceptable for patients to be harmed by the health care system that is supposed to offer healing and comfort--a system that promises "First, do no harm."

The Institute of Medicine (IOM) "To Err is Human: Building a Safer Health System"

Additionally**, people with disabilities**, particularly those with intellectual disabilities, **remain disproportionately at high risk for violent victimization, abuse and neglect.** People who provide care and support to individuals with disabilities, such as relatives and other caregivers, at times do not have access to the training, tools or resources available to carry out their duties effectively. Sadly, the stress created by the situation too often results in these same caregivers victimizing those for whom they care. Missouri's media have highlighted this issue recently in DMH facilities.

Table 4: Key Issues identified in NARI:

- Prevalence of preventable medical errors
- Abuse and neglect
- Pervasiveness and disabling nature of trauma
- The high rate of occupational safety in the health and social services fields

Trauma research reveals that many individuals with mental health, substance abuse and developmental disabilities may have already experienced a traumatic event (i.e. child abuse, sexual assault, military combat, domestic violence) prior to seeking help which compounds the above issues. The NARI summarizes that nationally, the majority of adults in psychiatric hospitals diagnosed with major mental illnesses have experienced physical and/or sexual abuse in their lives. Most of these individuals experienced the abuse as children. In Missouri, of the clients seeking residential and outpatient substance abuse treatment, 64% of women and 16% of men reported being physically or sexually abused. As indicated earlier, persons with intellectual disabilities are at disproportionately higher risk for abuse and neglect. **The scope of psychological trauma is pervasive. When psychological trauma is not recognized or addressed, people may be unintentionally re-traumatized by the agencies and providers serving them.** Consider the use of seclusion and restraint in mental health inpatient and residential settings. It creates significant risks for adults and children—risks that not only include serious injury or death, but also re-traumatization.

(NASMHPD NTAC 2005; Smith et al 2005; Jonikas et al 2005). Frequently, the mental health workforce fails to recognize or address the serious psychological impacts of unresolved trauma in the lives of the consumers in the mental health system. These issues can be exacerbated for people receiving care in non-mental health settings such as nursing homes, prison wards, etc. where staff may not only lack knowledge about trauma but about mental health as well.

Not only are systems of care frequently unsafe for consumers, but also they may be unsafe for the staff. U.S. Bureau of Labor Statistics data show that in 2000, 48% of all non-fatal injuries from occupational assaults and violent acts occurred in health care and social services. **After law enforcement, persons employed in mental health settings have the highest rates of all occupations of being injured while on duty.** Physical safety is not the only concern. In *"Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation,"* Sandra Bloom, M.D., states that ***"our helping systems are chronically stressed."*** Dr. Bloom explains that the national mental health system has experienced what she calls "collective systemic trauma." This is due to the numerous changes over the last 20 years as institutions downsized and community mental health systems decreased their scope of service. She suggests that these changes resulted in a significantly heightened level of individual and organizational psychological stress for the programs struggling to respond to their clients' needs.

Where do we need to go in Missouri?

"First do no harm" is the starting point in transforming the mental health system to ultimately create a culture of hope for those in care and their caregivers. From the public health perspective, the essential services most relevant to this include:

- Enforce laws and regulations that protect health and ensure safety.
- Ensure a competent public and personal mental health care workforce.
- Evaluate effectiveness, accessibility, and quality of personal and population-based mental health services

Recently, Missouri made great strides in addressing safety issues (identified within the NARI and illustrated in Table 5) and continues to build upon these transformative successes. For example, serious safety issues were identified within DMH in 2006. Gov. Blunt swiftly established a Mental Health Task Force (MHTF) to investigate and identify recommendations for a safer mental health system. Senate Bill 3 was introduced to improve safety measures and ensure appropriate, consistent penalties for violators. The MHTF and state legislature's efforts included multiple stakeholder perspectives and solution-oriented discussions. This resulted in sound actions for implementation and also launched the psychological healing process necessary for the people who had been impacted by the system's flaws. The development and endorsement of a safer mental health system moves Missouri closer to a culture of hope.

Table 5: Highlights—Missouri Successes and Strategic Developments

- In 2006, Governor Blunt appointed **the Mental Health Task Force (MHTF)** to investigate safety concerns. The MHTF issued a final report in November 2006 and incorporated recommendations from Missouri's Mental Health Commission developed earlier that same year.
- **Senate Bill 3, the Mental Health Reform Bill,** incorporated many of the key recommendations offered by the MHTF that required legislative changes. Missouri has made significant progress in addressing safety problems This progress is documented in the **DMH Safety Report.**
- The DMH has a **Trauma Position Statement** and has also identified necessary staff core and specialty competency requirements.
- To address **preventable medication errors**, the Governor's-recommended FY09 budget includes proposed funding for electronic applications including bar-coding to improve medication- administration-accuracy in DMH hospitals.
- The Fulton State Hospital implemented an organization wide initiative **Focus on Safety: Building a Culture of Partnership & Recovery** through a three- year SAMHSA grant on seclusion and restraint .

To create Communities of Hope, Missouri must begin by inspiring hope in the settings where care is delivered. Among the challenges faced by mental

health and other caregivers is to maintain compassion and respect for, and inspire hope in, every person to whom they provide services. Thus, Missouri must accelerate efforts to promote caring employees who feel supported in their jobs, who possess the skills and tools necessary to work with consumers, who are fairly compensated, and who have a passion for their work. Additionally, the mental health system must monitor and manage the risks associated with the care it delivers. Full use of available technology should support workers in providing safe and effective care. A disciplined approach to monitoring, analyzing data and responding to crises must occur. Underlying causes must be examined and appropriate information shared to engage workers in proactive systemic transformation.

To support such efforts, **Missouri must promote a trauma-informed system across all human service agencies.** Given the prevalence of trauma among consumers, and the history of abuse and neglect, Missouri's treatment systems should assume that all clients may be trauma survivors and treat them accordingly. A "trauma informed" system provides services that accommodate the vulnerabilities of trauma survivors. Services are delivered in a way that avoids inadvertently re-traumatizing individuals and facilitates consumer participation in care. It also requires, to the extent possible, close collaborative relationships between public sector service systems serving these clients and the local network of private practitioners with specialized clinical expertise in the treatment of trauma. Administrators must also be "trauma sensitive" regarding how past and present experiences impact individual attitudes, leadership styles, and group performance within organizations. A system cannot be truly trauma-informed unless the system can create and sustain a process of understanding itself. Missouri must continue to engage in broad-based "solution-oriented" dialogue that incorporates the perspectives of multiple stakeholders to address these complex issues.

How will we know we are successful?

In a ***transformed system*** consumers and families feel safe in seeking the help they need and their first encounter with the service system instills hope. Care is provided in safe, secure and therapeutic environments. Caregivers maintain compassion and respect for, and inspire hope in, every person to whom they provide services. Staff possess the skills and resources to perform their jobs safely, reducing the risk of both physical and psychological harm to themselves and those entrusted to their care. Workers are supported by caring, competent supervisors and managers who establish effective policies and systems to monitor, manage and reduce risk. Quality improvement promotes organizational and individual learning and systemic solutions to address the root causes of problems. Staff and consumers are actively engaged in activities that promote healing and hope.

TRANSFORMING FROM "NO WHERE TO GO" TO EASY, EARLY AND EQUAL ACCESS TO SERVICES AND SUPPORTS

What is the Issue?

Although Missouri's safety priority for those receiving metal health services is paramount as indicated in the first theme, a concordant mantra across Missouri is that ***"there is no where to go."*** Currently, there is an unhealthy tension between demand and supply of mental health services. Providers often say no to those in need to maintain a safety and quality balance for those already in care. Key issues related to accessing care are detailed in the NARI and depicted in Table 6. Sadly, the quality vs. quantity dilemma has resulted in a system of care where ***a person literally needs to hit rock bottom before getting help***. This is evidenced by the long waiting lists and the increasing demand placed on emergency rooms and institutional care settings, including those not designed for mental health services such as jails and prisons. Missouri's lack of service capacity perpetuates a culture of crisis with broad implications not just for the safety of people in care but also for those who are seeking it. Further, ***consumers in the system are afraid to leave it for fear of being unable to get back in if they need to return***.

"We do not tell cancer patients to come back if and when their disease has metastasized. But we turn mental health clients away and tell them to return when their symptoms are so severe and persistent that they cannot meet their own needs."

"Organizational Stress as a Barrier to Trauma-Sensitive Change and System Transformation"

Sandra Bloom , M.D.

Geographic and cultural disparities compound the crisis for many citizens. The NARI documents the rural nature of the state and the multitude of cultural and age groups residing here. Not surprisingly, 89% of Missouri's 114 counties are considered mental health professional shortage areas. Although mental health needs are relatively similar across cultures and geography, problems of accessibility, acceptability and availability cause many consumers to enter into treatment at later stages of their illness.

Table 6:

Key Issues identified in NARI:

- Barriers to Access Care
- Geographic Disparities
- Cultural Disparities
- Lack of Employment, Housing and Transportation Supports

Unfortunately, research shows that ***any delay in accessing care has damaging results.*** The National Co-morbidity Survey Replication (NCS-R, NIMH2005) study documents that the pervasive delays in getting services tend to occur for nearly all mental disorders. Unlike most disabling physical diseases, mental disorders often begin very early in life. Half of all lifetime cases begin by age 14; three quarters have begun by age 24. While approximately 80% of persons with a mental disorder in the United States *eventually* seek treatment, there are public health implications from long treatment delays. ***Early-onset, untreated mental disorders are associated with school failure, teenage childbearing, unstable employment, early marriage, marital instability and violence. Untreated psychiatric and substance use disorders at any age can lead to more frequent and severe episodes, and are more likely to become resistant to treatment***. These statistics have far-reaching implications as they suggest that people may end up requiring a higher level of public supports and services across human service agencies and more intensive mental health services than would be needed had they received appropriate intervention early. A lack of affordable services and a fragmented financing system were cited in the NARI as key issues related to insufficient service capacity. A lack of specialty mental health service providers was also cited as a key issue. Also, though primary care was found to be a major setting for the potential recognition of mental

health needs especially for children, adolescents and the elderly; trained staff, adequate reimbursement and options for referral to specialty care are limited.

Along with accessing care, consumers and families face multiple barriers to accessing services and supports needed to successfully ***live, learn, work and participate fully in the community***. A good education has long been recognized as one of the most significant predictors of success in later life. However, the Centers for Disease Control (CDC) estimate that 5% of children have mental health issues significant enough to interfere with learning.(Missouri Comprehensive Children's Mental Health Plan, December 2004) Most schools have neither the expertise nor resources to address these needs. This not only impacts potential educational success for those needing mental health supports, but also detracts from educational resources for other students.

Additionally, the New Freedom Commission found that **undetected, untreated, and poorly treated mental disorders interrupt careers, leading many into lives of disability, poverty, and long-term dependence.** Although people want to work and can work with modest assistance, people with mental disabilities (mental illness and developmental disabilities) have the worse level of employment of any group of people with disabilities. Understandably, they also have the highest rate of poverty than any other disability group (Houtenville 2006 Disability Status Report) making it extremely difficult to afford services. Transportation, employer perceptions, lack of employment supports, and fear of losing public medical benefits and access to public housing contribute to employment difficulties.

Affordable housing and residential treatment alternatives are also quite limited and poorly distributed across the state. Persons with mental disorders are disproportionately represented in the homeless population in Missouri. Stable, safe, quality and affordable permanent housing is a key to successful community living. However people typically cannot afford to buy or rent housing, even with financial help from existing government housing assistance, given the gap between the level of income support received and the prevailing housing market rates.

Table 7: Highlights--Missouri Successes and Strategic Developments

- **SB1003/Custody Diversion Protocol** eliminates the need for Missouri families to give up legal custody of their children just to access mental health care.
- In September 2007, Governor Matt Blunt proposed the **Insure Missouri** health care plan to help nearly 200,000 of Missouri's lower income, uninsured workers buy health insurance.
- Missouri has had 23 S**helter Plus Care Grants** awarded to the State.
- **Blue Ribbon Panel on Autism** issued a comprehensive set of recommendations to improve services for persons impacted by autism.
- **Chief Justice initiative on Mental Illness** is leading the state to create effective diversion and reentry strategies from the legal system for persons with mental illnesses.
- **The Money Follows the Person Rebalancing Demonstration** will enable individuals living in facilities to transition to communities with supports and services from the Divisions of Senior and Disability Services (DSS) and MRDD (DMH).
- FYO8 budget increased funding to MRDD to reduce the Division's **waiting list.**
- With support from the Department of Elementary and Secondary Education , many local Missouri schools have implemented the **Positive Behaviors Supports (PBS) model.**
- **ADA Access to Recovery Initiative—**SAMHSA awarded second 3-year funding to DMH ADA to engage faith-based and non-traditional community providers in delivering, ensuring client free choice of, and improving client access to substances abuse treatment and recovery support services.

Where do we need to go in Missouri?

Transforming the mental health system to one that promotes easy, early and equal access is a daunting task given the large number of people uninsured and underinsured. Due to resource constraints, many agencies screen out all but those in the most serious need. From a public health perspective the essential services most relevant to this issue include:

- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based *Mental* Health Services
- Diagnose and Investigate *Mental* Health Problems and *Mental* Health Hazards in the Community
- Link People to Needed Personal *Mental* Health Services and Assure the Provision of *Mental* Health Care when Otherwise Unavailable

Missouri's progress and recent accomplishments are highlighted in Table 7. For example, **the ground-breaking passage of Senate Bill 1003 eliminated the need for Missouri families to give up legal custody of their children just to access mental health care.** Missouri's Blue Ribbon Panel on Autism recently issued recommendations to create a comprehensive system of care for persons and their families impacted by autism and the Governor's FY09 budget proposal includes funding to increase autism treatment services. Currently, the Governor is promoting ***Insure Missouri*** to extend health and mental health care coverage for up to 200,000 of Missouri's uninsured workers.

These and other initiatives begin to move the system to one where easy, early and equal access to care is the norm rather than the exception. Diversion actions similar to the SB 1003 custody diversion provisions need to be expanded to other systems and populations. Specific examples include the juvenile and adult justice systems that, although mandated to provide care, are often ill-equipped to offer effective mental health services. Service capacity must be increased and a broader array of effective community-based services offered to promote early intervention and reduce the need for potentially unnecessary and expensive institutional care. Strategies to improve the effectiveness and efficiency of the system must be implemented in conjunction with new funding for services that will have the most significant impact. Missouri must build upon the current NARI to identify and address gaps in care including those directly tied to culture and geography.

For young persons, the early childhood and school settings offer an excellent opportunity to intervene. Although mental health services are offered in some schools, Missouri needs to establish a comprehensive, consistent statewide program. Other access points need to be considered as well. As the primary care physician is often the first point of contact, training and collaborative partnerships need to be established to provide needed mental health care or referral. Also, community service and support options must be developed including employment, housing and transportation opportunities that enable people to become more self-sufficient. Finally, procedures and processes must be developed to allow consumers to quickly re-enter the system and access the broader array of services when needed.

How will we know we are successful?

In ***a transformed system***, the early detection of mental health needs is common practice and mental health screenings are accepted, routine components of physical exams. Early intervention occurs in low-stigma settings such as schools and primary care offices as well as high-risk settings such as the justice and child welfare systems. No individual has to enter the justice or protective services system just to access the care they need. Missourians can enter the system with ease and exit the system without fear of losing needed services and supports. All Missourians share equally in the best available services and outcomes, regardless of race, gender, ethnicity, or geographic location. A qualified workforce is available to meet the needs of consumers statewide. Children thrive in schools, adults thrive at work and persons of all ages have access to the opportunities to live, learn, work, and participate fully in their community.

TRANSFORMING FROM A DISABILITY FOCUS TO A FOCUS ON WELLNESS WITH PREVENTION AND EARLY INTERVENTION

What is the Issue?

The current unhealthy tension that exists between "quality vs. quantity" discussed in the first two strategic themes apply to people actively seeking or already in care. However, little focus has been given to mental health promotion and illness prevention, cornerstones of the public health model, which can help to alleviate this systemic stress. Michael Hogan, Ph.D., Chair of the New Freedom Commission, stated in a July 23, 2003 interview in the *Washington Post* that, ***"We have an 'unintended conspiracy' to keep people disabled."*** Unfortunately, this "unintended conspiracy" has broader implications. Although the barriers to accessing care once people want it are daunting**, people nationwide avoid accessing care until symptoms are debilitating and disabling**. Thus, the system is designed to not just "keep people disabled" but often promotes them to become disabled prior to ever seeking help. The system focus "downstream" vs. "upstream" actually places more demand on the system than would otherwise be necessary. Key issues identified in the NARI are outlined in Table 8.

"To improve the system, it will be necessary to look beyond who is already in the system to the greater population and seeing care happen on a broader continuum that begins with health promotion and illness prevention, includes treatment, and supports the process of recovery throughout."

—National Association of State Mental Health Program Directors (2004)

Missouri currently dedicates few resources specific to mental health promotion and prevention. For example, state eligibility criteria typically require a particular diagnosis to receive services coupled with criteria that requires a person to demonstrate an inability to carry out daily life functions in one or more areas. **Sadly, the mental health system stands in stark contrast to the public health system that focuses on health education, promotion and regular wellness check-ups**. The current approach is costly, in terms of both human and financial capital.

Unfortunately, the lack of public health literacy related to mental health impedes promotion and prevention. The literature suggests that **laypeople have a poor understanding of mental disorders as well as the effectiveness and availability of various treatments and supports**. The 2004 U.S. Institute of Medicine (IOM) report titled *"Health Literacy-A Prescription to End Confusion"* indicates that people with limited health literacy tend to have poorer health, are less likely to use preventative services, have less knowledge of health promoting behaviors, and are less able to manage disease. The prevalence of mental disorders means that most Missourians eventually have contact with someone with a mental health problem, but often lack the knowledge to accurately recognize the problem and provide helpful resources. The inability to recognize a disorder in oneself or others could result in delays seeking appropriate treatment, utilization of inappropriate remedies, or difficulties communicating with health professionals.

Table 8: Key Issues identified in NARI:

- Lack of Prevention
- Poor Mental Health Literacy
- Stigma & Discrimination
- Lack of Integration between Mental Health and Physical Health Care

Stigma and discrimination pose even greater barriers. **Stigma has been identified as the most formidable obstacle to future progress in the arena of mental health.** The 1999 Surgeon General's Report described the impact as follows: "Stigma erodes confidence that mental disorders are valid, treatable health conditions. It leads people to avoid socializing, employing or working with, or renting to

or living near persons who have a mental disorder. Further….**stigma deters the public from wanting to pay for care and, thus, reduces consumers' access to resources and opportunities for treatment and social service. Stigma tragically deprives people of their dignity and interferes with their full participation in society."** The NARI found stigma to be one of the most significant and pervasive issues identified across all stakeholder groups involved in the assessment. The stigmatization of people with mental disorders has persisted throughout history and research indicates that knowledge alone does not defuse it. (Lauber C, Nordt C, Falcato L, et al 2004) Thus stigma can persist even with education. The media also bear responsibility for perpetuating stigma. Although the relationship between the media and public perceptions is complex, the media exert influence, and negative media images are of concern because they increase psychological distress and fear of persons with mental disorders. (Levin 2001)

The historical segregation of mental health and physical health has contributed to and continues to compound the above issues. The inter-relationship between physical and mental health is well documented—mental health problems often contribute to poor health outcomes and vice-versa. Yet in practice, neither prevention nor treatment is often coordinated. This not only results in poor health outcomes but also contributes to the lack of understanding and stigma in the general public.

Where do we need to go in Missouri?

Adopting a public health approach in Missouri requires a broader view of mental health, one that integrates health promotion and prevention within the full spectrum of mental health services. **This broader view is based on evidence that when more prevention is undertaken, less people will reach a point where they need increased and more expensive care.** Prevention activities are generally directed against risk factors and are implemented at specific periods before the onset of a problem or disorder. Once a problem or disorder has developed, however, preventive interventions are still useful to reduce the severity, course, duration, and disability associated with the problem. The essential public health services most relevant to this goal include:

- Inform, Educate and Empower People about *Mental* Health Issues
- Mobilize Community Partnerships to Identify and Solve *Mental* Health Problems
- Develop Policies and Plans that Support Individual and Community *Mental* Health Efforts
- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based *Mental* Health Services

Table 9: Highlights—Missouri Successes and Strategic Developments

- Missouri's **Strategic Prevention Framework State Incentive Grant (SPF SIG)** is helping Missouri coordinate prevention initiatives across state agencies & to promote evidence-based strategies to prevent substance abuse.
- Missouri's development of a S**tatewide Suicide Prevention Plan** to address the high suicide rate in Missouri (12.9/100,000) has brought about positive changes at the local level.
- The **Coordinating Board for Early Childhood (CBEC)** was established to serve as the public/private entity for coordinating a system of early childhood programs for Missouri children from birth through age five.
- **Missouri's First Steps** Program offers coordinated services to children birth to three with delayed development or conditions that are associated with developmental disabilities.
- **Missouri Substance Abuse Prevention, Intervention and Resources Initiative (Spirit)** supports development/ implementation of a continuum of evidenced-based SA prevention services in K-12 public schools.
- Several Missouri schools have adopted the **Positive Behavioral Support** Model to support healthy emotional development and foster resilience in children.
- **FQHC/CMHC Collaboration:** In FY 2008 the legislature appropriated funding to pilot community mental health centers (CMHCs) and federally qualified health centers (FQHCs) collaborative care in seven pilot sites.

Missouri has made much progress as highlighted in Table 9**.** For example, the adoption of the positive behavioral support model by some Missouri schools promotes cost-effective, proactive systems of behavior support at the school level. Also, the development of a state-wide Suicide Prevention Plan has

resulted in over 15,000 citizens being trained to recognize the signs and symptoms of suicide across the lifespan and assist them to get the help they may need. **Missouri is now at a critical point with a real opportunity to fundamentally rethink mental health and health care**. Missouri must build upon its recent initiatives to develop a common frame of reference that emphasizes wellness, including mental wellness as a goal important to all Missourians. As the development of mental health problems often occur early in life; social, emotional, and behavioral well-being must be promoted as an integral part of a child's healthy development. Early identification of mental health needs should be facilitated in existing preschool, childcare, education, health, welfare, juvenile justice, and substance abuse treatment systems. Prevention must not only be applied in childhood but across the lifespan, including the prevention of late-onset depression and suicide, excess disability, and premature institutionalization. Missouri must also invest in evidence-based prevention methods that emphasize the importance of access and supports in community settings that contribute to wellness and begin integrating health promotion into mental health care settings. Because multiple problem behaviors that relate to mental health at some level have been found to have common causes, a shared prevention framework should be developed emphasizing interventions that can impact multiple behaviors.

Missouri must also actively engage and invest in improving mental health literacy in the overall population. **The public needs and deserves to know what to do when encountering a potential mental health problem personally or in others**. Conversely, Missouri should take the necessary steps to assure general health literacy efforts incorporate the needs of persons with mental illnesses, developmental disabilities and addiction disorders. As stigma was found to be one of the most significant and pervasive issues, and key barriers to transformation, the need to incorporate anti-stigma promotion into the overall mental health prevention and promotion framework is critical. Efforts to eliminate it must be multi-dimensional and address the attitudes held by mental health and health professionals as well as the general public. Finally, because mental health is intrinsically related to all health aspects, it is imperative to approach mental health within the context of overall health by integrating public health, primary care and mental health practices.

How will we know we are successful?

In a ***transformed system*** mental health is pursued with the same urgency as physical health and Missourians view mental health as essential to their overall health and well-being. The public is educated about mental illness, addiction disorders and developmental disabilities and stigma does not exist. Educated and caring citizens are actively engaged in promoting mental health and wellness, and in supporting recovery and self-determination. Missourians know how to identify mental health issues and how to respond to their own or others' mental health needs. The mental health needs of Missourians are treated as an overall component of their physical health and people know when one component may be affecting the other. People are eager to seek the care they need and the public is willing to absorb the cost.

TRANSFORMING FROM A BUREACRACY/PROVIDER DRIVEN SYSTEM TO CONSUMER DIRECTION AND EMPOWERMENT

What is the Issue?

There is a Chinese proverb that **''no one knows better how the shoe fits than the person who wears it.''** Yet in Missouri, as elsewhere, consumers are neither in charge of defining the care they need nor in exercising informed choices in the care they receive. **As Missouri moves to promote wellness and create a culture of hope within the mental health service system, consumers must be provided with the tools and supports to manage their own mental health**. Professionals must move from a more paternal role to a teaching and coaching role.

"You keep talking about getting me in the 'driver's seat' of my treatment and my life … when half the time I'm not even in the damn car!"

– quote from a woman on her experiences of treatment planning; (Tondora, et al, 2005).

Key issues are identified in the NARI and highlighted in **Table 10**. For example, consumers often lack decision-making power to direct their care. The mental health system predominantly relies on a provider-driven model of service delivery that uses *traditional* planning methods where mental health care decisions are prescribed by professionals. In addition, a professional or expert often determines the plan(s) of care. This practice can unintentionally perpetuate dependence rather than self-direction and wellness. A wellness model empowers service participants to establish their personal mental health goals and manage both their mental health and plan of care through education and supports.

Programs that promote real self-direction are rare in the mental health system because 1) the workforce often lacks the knowledge and skills needed to conduct them, and 2) institutions, at the provider, organizational, and government levels, lack the culture and processes needed to promote them. **Many in the workforce lack familiarity with wellness-oriented practices** to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options. This unfortunately can lead to policies and practices that lack respect and individualization, and negatively impact a consumer's ability to take charge of his/her treatment and life. Such practice can also perpetuate internalized stigma, by reinforcing a sense of negative self-worth in individuals due to the perceived unequal balance of power between professionals and consumers. The NARI referenced this in findings from the "Voice of the Consumer" survey conducted by DMH where some consumers voiced concerns and provided examples regarding poor staff attitudes and practices. In some situations, consumers felt that staff treated them more like "criminals"—not clients—with little respect. Some persons in in-patient care settings said they had house rules that did not apply to the staff regarding cursing, smoking, etc. A general consensus exists that the staff have a direct and profound impact on a person's satisfaction level.

Table 10: Key Issues identified in NARI:

- Lack of Consumer decision-making and self-direction
- Policy makers are not informed by Consumers & Families
- Lack of recovery and support services

The lack of consumer input is not only a problem at the service delivery level. Missouri's mental health system does not fully incorporate the consumer and family voice in the policy-making process as well. Although several formal structures exist for policy and planning input (*e.g. State Mental Health Commission, State Planning and Advisory Councils, Children's Stakeholder Advisory Group, Consumer*

Affairs Offices and private advocacy and self-help organizations), consumers and families lack a structure for ongoing, meaningful consumer and family-directed policy and program development beyond DMH. **Consumers and families feel they have little to no voice in the policy-making and budget processes of other state departments that provide mental health care.**

From the perspective of workforce planning and development, the amount of services provided by mental health professionals and other health and human services providers pales in comparison to the level of self-care, peer support, and family care giving that occurs. Individuals with mental health problems, along with their families, are a human resource that too often has been overlooked or underutilized. (Annapolis Coalition-An Action Plan for Behavioral Health Workforce Development, 2007) Recognizing consumers as providers is a relatively new concept within some parts of the mental health system. The traditional provider-driven model has often established strong boundaries between the provider and the service participant. However, emerging evidence strongly supports the need for peer and family support services as a cost-effective and complementary adjunct to professional mental health services and supports.

Where do we need to go in Missouri?

Placing the consumer in charge requires a fundamental shift in the culture of Missouri's mental health system. **Consumers are the bridge between the mental health system as it exists now and the system as it should be.** It is their life and hope for the future at stake. Therefore, their needs, wants, and goals should guide the decision-making process at all system levels. Creating a system that meets their needs fully is not only a critical part of Transformation, but also the **reason** for undertaking the difficult and necessary work ahead. **Missouri must provide equal weight to expertise gained through the "lived experience" as is done with any other credential or knowledge base**.

Table 11: Highlights—Missouri Successes and Strategic Developments

- The division of MRDD has established a variety of mechanisms for consumers to successfully **self-direct services and supports.**
- A CMS grant awarded in 2007 will enhance the use of **person-centered planning practices** for persons with developmental disabilities or mental illness, integrating the philosophy through the system.
- The Comprehensive System for Children has successfully developed a **Stakeholder Advisory Group** comprised of more than 50% family and youth involvement as well as a **Youth Involvement Cooperative.**
- DMH is participating in the development of **best-practice and fidelity standards for consumer-operated services** to assure their ultimate credibility and success.
- Missouri has successfully piloted the **Procovery Program** developed by Kathleen Crowley and has recently developed the infrastructure necessary to take the program state-wide as part of the system transformation effort.

From a public health perspective, the essential services related to this strategic theme include:

- Inform, Educate and Empower People about Mental Health Issues
- Develop Policies and Plans that Support Individual and Community Mental Health Efforts

Before consumers participate in decision-making, they must be empowered. The first step is obtaining information about their choices and access to training and supports to follow through on their decisions. Mental health providers, from agency directors to line staff, must have the tools needed to successfully accomplish this system change. A fundamental shift in organizational culture needs to occur: from one currently focused more on treatment compliance and risk avoidance toward one of informed choice and effective risk management. Promising and evidence-based practices in illness self-management, such as those promoted by SAMHSA must be incorporated in daily care and treatment. In reviewing practices used within the public health field, other promising models could be applied to mental health as well. For example, the Center for Disease Control is promoting the adoption of Wagner's Chronic Care Model by the healthcare system as an approach to empowering and preparing consumers to manage their health and health care. Another indispensable tool to moving the system to one that is

consumer-driven is person-centered (*or family centered/youth guided*) planning. Person-centered planning is a process-oriented approach to empowering people that has been adopted in the developmental disabilities field. The person-centered approach relies much less on the service system by organizing truly individualized, natural, and creative supports to achieve meaningful goals based on the individual's strengths and preferences. For families and their children who have serious emotional disturbances, wrap-around planning employs a similar approach. In adopting this new focus, Missouri must also begin to develop policies and technological supports to create individualized care plans that are integrated across agencies involved in a person's care and treatment and developing mechanisms whereby consumers can have integrated personal budgets to effectively choose and manage their support services across agency funding streams.

As Missouri's mental health system moves to a public health approach, consumers and families should inform and guide policy developers. Their insights are based on system experiences and provide a richer, more complete understanding of the issues. Additionally, consumer participation and feedback can 1) counteract the fear and distrust that might surface from limited contact between consumers and government officials, and 2) enhance surveillance and evaluation components to policy or program development. Such feedback can improve program quality, enhance professional development, impact program design, and improve the provision of services and supports.

Additionally, Missouri's concept and definition of workforce must be expanded to include consumers and family members. They are pivotal members of the workforce due to their critical roles in caring for themselves and each other. Peer and family support services can move the system to focus less on illness and disability and more on wellness. They aim to maximize the opportunities to create a lifetime of wellness personally and for family, neighbors, and community.

How will we know we are successful?

In a ***transformed system***, savvy and knowledgeable consumers and families know what care and support they need, how to get it and how to evaluate it. They are empowered through education and support to move forward with their lives and to manage their own plan of care. Providers, administrators and policy-makers hold a deep and enduring respect for the persons they are privileged to serve. Consumers, in partnership with their caregivers set in motion a person-centered planning approach owned by consumers, embraced by providers and defined in a single plan of care. There is a system-wide focus on wellness with consumers and families involved in leadership, support and service provider roles throughout the state. Consumers and families have an active voice in designing and developing the systems of care in which they are involved. Mutual respect guides the process of shared decision-making at all levels of the system.

TRANSFORMING FROM POCKETS OF EXCELLENCE TO UNIVERSAL BEST PRACTICES

What is the issue?

Not only do people need easy, early and equal access to care, but they also need access to new treatments and the successful, evidence-based treatments already developed through research. A national array of evidence based and promising practices allows for successful treatment and supports for the majority of people with mental health needs. Such advances support people in living full and productive lives in the community. However, **most Missourians are not benefiting from these scientific advances** for complex and varied reasons. Key issues are identified in the NARI (Table 12). First and foremost, serious workforce problems exist. Not only is there a shortage of mental health professionals, but also the available providers often lack training in evidenced based and other promising practices. Changes in health care have outpaced changes in the educational programs offered to the mental health workforce. The result is a training gap that often leaves graduate students and direct care providers inadequately prepared for practice in the current health care environment. The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported.

"When you pit a bad system against a good performer, the system almost always wins"

(Rummler, 2004)

The IOM report "Crossing the Quality Chasm" identified several barriers to delivering excellent care, i.e. current shortage and maldistribution of workers; work environments that do not support excellent service delivery; a lack of diversity and cultural expertise; outdated educational/ training content and methods; variation in the scope of practice and assurance of competencies; and concerns about legal liabilities. The varied backgrounds of professional and non-professional mental health staff along with their wide array of practice settings significantly compound the problem. **There is no agreed-upon level of competency within any profession, much less *across* professions with respect to providing mental health care**. The numerous education institutions providing training are often inadequately grounded in the scientific evidence-base for treatment. One workgroup member stated **"It's just not right. We have to completely retrain people once they graduate just to implement an evidence based practice."** A primary concern about professional staff education and training is the absence of clearly specified competencies that must be developed and a process for assessing whether these competencies are achieved. The financing of continuing education is a critical issue. Missouri providers have significantly scaled-back training due to budgetary constraints. Often public and private policy and reimbursement methods compound this problem. Specifically, reimbursement complexities and limitations cause the quality of mental health services to vary greatly (IOM).

Table 12: Key Issues identified in NARI

- The Mental Health Workforce Crisis
- Evidence-based Practices-the Science to Service Gap
- Lack of Comprehensive Quality Management Structure

The NARI identified that Missouri has a number of facilities and community provider agencies using components of evidenced based practices (EBP) to improve service outcomes; however, the availability of these services varies greatly statewide. Variability also exists in the practices delivered as no infrastructure exists in the state to provide technical assistance, support fidelity reviews, and measure outcomes distinct to EBP implementation. Missouri has yet to achieve consensus on the definition,

utility and approach to EBPs, although much progress was made to address this in the Transformation planning process by the EBP workgroup and the TWG.

Compounding this issue is the lack of a state-wide research and evaluation infrastructure in Missouri to build an adequate science base that supports innovative promising practices. Also, there is no comprehensive quality management structure. In recent years, significant time and attention has been devoted to reduce variations and improve the effective delivery of care in the overall healthcare industry. This has not received equivalent attention in mental health. Fewer measures of safety, quality and timeliness exist, partly due to the historic separation of mental health from the general healthcare field. When looking at population-based measurement systems essential to a public mental health approach, the picture is even bleaker: measures and data sets are virtually non-existent.

Where do we need to go in Missouri?

Implementing best practices statewide that are universally available takes the safety issue to the next level—services are not only safe but also highly effective. The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported.

Universal application of proven techniques to produce consumer-desired outcomes should increase the efficiency, access to and capacity of the mental health service system. An investment in research and evaluation of new and promising practices along with a comprehensive quality management infrastructure will accelerate best practices. The essential public health services most relevant to this issue:

- Assure a Competent Public and Personal *Mental* Health Care Workforce
- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based *Mental* Health Services
- Research for New Insights and Innovative Solutions to *Mental* Health Problems
- Develop Policies and Plans that Support Individual and Community *Mental* Health Efforts

Missouri has successfully launched several initiatives to achieve this as highlighted in Table 13 and must build upon these successes. First and foremost, achieving the promise of a transformed mental health system requires a workforce that is sufficient in size, with the necessary competencies, and fully supported by the work environment to provide care consistent with these competencies. A. Kathryn Power, director of the Center for Mental Health Services (CMHS) at SAMHSA, **described the need to develop and change competencies at three levels to effect a transformational system change**: ***the individual level*****,** which includes both providers and educators; ***the organizational level*** which includes

Table 13: Highlights—Missouri Successes and Strategic Developments

- **Missouri's DMH/MO HealthNet Pharmacy Improvement Partnership** promotes evidence-based prescribing practices and has significantly reduced pharmacy costs and hospitalizations without resorting to mandatory restriction on medications. Missouri won the American Psychiatric Association's Bronze Achievement Award in 2007.
- Missouri is implementing several **Evidence based practices** including Assertive Community Treatment (ACT), Integrated Dual Diagnosis Treatment (IDDT): Dialectical Behavioral Therapy (DBT) and Supported Employment Services (SE)
- **Office of Juvenile Justice and Delinquency Program (OJJDP) Grant**—DMH and OSCA joint field demonstration in 5 sites to strengthen community interagency collaborations , implement EBPs to address youth with mental health issues in child welfare or juvenile justice systems; improve quality of mental health assessments to courts and child welfare.
- MRDD is increasing skills of direct support professionals through the **College of Direct Support,** a web-based training program with nationally recognized curricula. The division is also participating in **The National Core Indicators** project, a multi-state collaborative to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies and share results.
- The **Children's System of Care Cooperative Agreement Sites funded through SAMHSA** have formalized training and program evaluation standards to assess fidelity of implementation of wrap-around services for children and families.

the organizations that deliver services and the academic institutions that deliver training and ***the governmental level,*** which consists of federal and state agencies, as well as accrediting bodies, health care insurers, and professional organizations. (Power, K 2005)

Missouri must take other steps to accelerate the adoption of EBPs. This includes developing a shared definition and a consistent and balanced approach across agencies. **An infrastructure for effective research dissemination and technical assistance must be established.** As promising new findings are disseminated to front-line providers, policies and financing must provide incentives to support their adoption and use. The successful and sustainable implementation of evidence based practices will require organizational and systems change to support practice changes. Direct service providers as well as supervisors and program managers, will need to increase their knowledge and learn new skills related to the new practice. Formal and informal organizational structures and cultures are needed to bring about and support the changes in service provider practices. Changes in policies, management, and relationships with external partners are also needed to support the implementation of new practice. An investment into research and evaluation along with a comprehensive quality management infrastructure that evaluates consumer desired outcomes is needed to accelerate best practices across the state.

How will we know we are successful?

In a ***transformed system*** Missourians regardless of age, culture or place of residence, receive excellent prevention, treatment and support services consistent with scientific understanding. An adequate, well-trained and highly competent workforce work with consumers and their families to create and maintain individualized plans of care. The care they offer focuses on the full range of supports people need to live a full life in their communities. Science informs the provision of services, and the experience of consumers and service providers guides future research. Data-driven quality improvement is the norm across the system and research is used to develop new evidence based practices to prevent and treat illnesses. These discoveries are immediately put into practice. People with, or at risk of developing mental illnesses, developmental disabilities and substance abuse disorders fully benefit from the enormous increases in the scientific knowledge base and the development of many effective treatments.

TRANSFORMING FROM A FRAGMENTED AND CENTRALIZED SYSTEM TO SHARED OWNERSHIP AND INVESTMENT

What is the issue?

"…no single goal or recommendation alone can achieve the needed changes. No level of government, no element of the private or public sector can accomplish the needed changes on its own. To transform mental health care as proposed, collaboration between the private and public sectors and among levels of government is crucial." **--NFC Report**

"Every system is perfectly designed to achieve exactly the results it gets"

(Berwick, 2003)

Integrating mental health policy, services and financing is a daunting but necessary challenge for Missouri's mental health and related human service agencies. **Consumers cannot take charge of their mental health services and lives if they can't understand, access or navigate the vast and fragmented system**. Missourians will not recognize and embrace mental health as being an essential component of overall health if the health and mental health systems continue to remain separate. The gap between scientific advances and community practice will continue if Missouri's education and research institutions provide training in discipline-specific silos. Inconsistent priorities and approaches to best practices across educators, policy-makers, benefits administrators and providers, and within communities must be addressed to move the system forward.

The existing mental health delivery system has unclear lines of authority, multiple public and private sector payers and providers, diverse stakeholders, and different types of evidence, standards of care, quality review methodologies and reimbursement policies. The mental health service system is complex and connects many sectors (public/private, specialty/general health, health/social welfare, housing, criminal justice, and education). As a result, care is organizationally fragmented, creating barriers to access. The system is also financed from many funding streams with often competing incentives between funding sources. **Currently mental health services in Missouri are provided or financed by over seven distinct state agencies** *(the Departments of Mental Health; Corrections; Elementary and Secondary; Social Services; Health and Senior Services; Public Safety and the Office of State Court Administrators),* **seven federal departments** (*the Departments Health and Human Services, Education, Labor, Agriculture, Veterans Affairs, Justice and Housing and Urban Development*), **local branches of government, employer-sponsored benefit plans and a multitude of charitable organizations**. Even within the private health sector, mental health services are fragmented. Despite important progress, the National Business Group on Health identified that within the private employer market, standardized and integrated programs addressing the delivery of behavioral healthcare services remain rare. In their "Employer's Guide to Behavioral Health Services" the group concluded that it is not customary for employers to integrate behavioral healthcare benefits offered through the health plan with benefits offered through disability management, employee assistance, or health promotion programs. The result is that employer-sponsored benefits for mental health care are fragmented, uncoordinated, duplicative, and uneven in terms of access and quality.

Table 14:
Key Issues identified in NARI:

- Fragmented and lack of coordination between state and local level.
- Lack of shared state and local authority and investment in mental health
- Need to improve financing system.

Unfortunately, there is neither a consensus nor shared agenda for what the mental health system should be. Education and research is often conducted in discipline-specific silos with no commonly agreed-upon standards. The mental health and health care system is not only complex but disjointed. Quality management standards and measures are wide and varied across public agencies and between public and private payers. The ability to integrate and analyze data is limited due to the lack of common measures and a shared data infrastructure across agencies. When attempting to capture population-based data essential to adopting a public health approach, measures and data sets are virtually non-existent.

The historical reliance on the state to provide and fund mental health services has the most profound implications. A large amount of federal funding is dedicated to provide primary care services to the uninsured through federally qualified health centers, rural health clinics and other health facilities. However, with the exception of very limited block grant funding through SAMHSA for substance abuse and mental health services, **no equivalent federal funding is dedicated to mental health care for the uninsured. This places a significant undue burden on the state,** especially in light of the extreme poverty rates that exist for the people in need of care. These historical policy decisions have contributed to decisions made to limit mental health coverage in the private sector as well, adding to the overall state burden. Not only are federal and private mental health benefits limited, but local funding for mental health services is not on par with funding for healthcare. Currently, most counties in Missouri have dedicated taxes for health services**. However, local funding for mental health services is variable;** while 83 counties and the City of St. Louis have taxes dedicated to meeting the needs of persons with developmental disabilities, **only 14 of Missouri's 114 counties have dedicated funding to meet the needs of people with mental illness and substance abuse problems.**

Table 15: Highlights— Missouri Successes and Strategic Developments

- Senate Bill 1003 was enacted in 2003. It required the development of a Comprehensive Children's Mental Health Service Delivery Plan and the establishment of the **Comprehensive System Management Team (CSMT**) that transcends state departments and other child-serving agencies.
- The Department of Corrections (DOC)and DMH-ADA have collaborated on an **Offender Re-entry Program**, showing gains in reducing the recidivism of addicted inmates released from DOC. More than 11,300 program participants did not return to the correctional system during the first 12 months of the program.
- Missouri has sanctioned 11 **Local System of Care Sites** and the Children's Comprehensive State Management Team is developing systems to support the expansion of such networks in counties throughout the state.
- The Regional Health Commission in St. Louis launched **a regional behavioral health transformation initiative** that has resulted in broad-based community action to improve access to care.
- ***FQHC/CMHC Collaboration:*** In FY 2008 the legislature appropriated funding to pilot community mental health centers (CMHCs) and federally qualified health centers (FQHCs) collaborative care in seven pilot sites.
- The Departments of Mental Health and Corrections have partnered with the Missouri Coalition of Community Mental Health Centers to pilot a project which will assist seriously mentally ill offenders in obtaining mental health treatment services within the community upon release from prison.

Where do we need to go in Missouri?

Mental health will never be viewed as essential to overall health unless responsibility is shared amongst all levels of government and between the public and private sectors**. Collaborative efforts are imperative to move policies, practices, and financing from bureaucratic constraints to human need and a consumer-driven system.** The following essential services of the public health approach are most relevant to creating a system of shared ownership and investment:

- Monitor Health Status to Identify Community *Mental* Health Problems
- Mobilize Community Partnerships to Identify and Solve *Mental* Health Problems
- Develop Policies and Plans that Support Individual and Community *Mental* Health Efforts
- Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based *Mental* Health Services

Missouri has demonstrated an ability to collaborate for change through multiple initiatives, a few which are highlighted in **Table 15**. The establishment of Missouri's Comprehensive System for Children is an excellent example and serves as a solid foundation for current transformation efforts to meet the needs of people across the lifespan. An enduring cross-agency structure must be established to ensure that a comprehensive state plan for mental health guides mental health policy far into the future.

Missouri must now fully engage in a community approach, the cornerstone of the public health model. Central to all transformation initiatives is mobilizing community support for changes at the local level. Missouri must view the community as an essential extension of its mental health workforce. This will require and challenge the state to work with individuals beyond the current service scope. Primary health care, schools, early childhood programs, senior programs and services, daycare across the life span, business, criminal justice and all of the other organizations that come into contact with persons at risk of needing mental health services must be involved. Prevention and early access to services and supports should be a top priority for all agencies, not just the state mental health system. Services must be coordinated and integrated across health, mental health and social service agencies.

State agencies must collaborate with local communities to 1) support community interagency efforts to assess systems, resources and needs necessary to form functional partnerships, and 2) ensure communities "map their assets" to develop new resources and leverage existing resources available from one another to better meet community needs. **They must also work together to eliminate inconsistent policies, practices and financing that currently serve a major barriers to receiving excellent care at the local level**. This will also require effective partnerships with the Federal government agencies that finance mental health services. Additionally, it will require partnerships with and among educational and research institutions to develop a common framework for education, a research dissemination infrastructure and agreed-upon core competencies for providers. State agencies must collectively establish a set of priority population and individual mental health measures. Such measures should be developed in partnership with private payers. To guide the collective action needed across all stakeholders, Missouri must invest in the technological and data analytics infrastructure needed to effectively collect, analyze and report these measures.

How will we know we are successful?

In a ***transformed system*** the burden of coordinating care rests with the system, not on the families or consumers who are already struggling due to the complexities of their illnesses or disabilities. There is no wrong door for persons to access services. Cooperation occurs at and among all levels of the system—federal, state and local; public and private. There is flexibility in the criteria for and financing of services, allowing services and supports to be individualized and seamless in meeting consumer and family. Consumers are included in their community's social fabric through meaningful and relevant work with adequate income and benefits; educational opportunities; personal relationships; recreational opportunities; recognition and respect from others, and a political voice. Everyone assumes responsibility and everyone is held accountable.

Part 2: Goals & Objectives

GOAL 1: MISSOURIANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH

OBJECTIVE 1.1:
INCREASE PUBLIC UNDERSTANDING AND REDUCE STIGMA OF MENTAL ILLNESS, SUBSTANCE ABUSE AND DEVELOPMENTAL DISABILITIES

Core Strategies:

Strategy 1.1a: Develop and conduct a social marketing/public information campaign to dispel myths regarding mental illness, substance abuse and developmental disabilities.

Strategy 1.1b: Develop and incorporate mental health education into health literacy programs and initiatives.

Strategy 1.1c: Develop a 7-12 grade curriculum of mental health competencies to be incorporated into state health curriculum.

Strategy 1.1d: Implement a widely accessible, e-based human services information sharing system for use by all levels of community agencies, providers, families, and consumers.

Strategy 1.1e: Build awareness and accountability for desired transformation outcomes.

OBJECTIVE 1.2:
DEVELOP AND IMPLEMENT A STATEWIDE PREVENTION FRAMEWORK THAT ADDRESSES COMMON RISK AND PROTECTIVE FACTORS.

Core Strategies :

Strategy 1.2a: Create a statewide prevention framework to address common risk and protective factors and develop a coordinated service system, approach, funding strategy and measurement system to be implemented locally.

Strategy 1.2b: Develop/implement pre-service and in-service training modules on predictive factors and prevention strategies for health, social service, school, etc. providers to implement.

Strategy 1.2c: Incorporate "5 Protective Factors" model to build parental resilience into philosophy and delivery systems of child-serving agencies.

Strategy1.2d: Implement State Suicide Prevention Plan and expand services to older adults.

In a Community of Hope:

"The public is educated about mental illness and there is no stigma. People see me as having a purpose in life, intelligent enough to work, capable of responsibility"
Camdenton, MO

"I would know more about mental health and how to get my health back together. I would have opportunities to go back to work and do more things."
Kennett, MO

"Mental health care would not be a dirty word or kept secret from others. The community would look at it as if receiving care for a physical illness."
Mexico, MO

"Mental health services will shift from a symptom-reduction model to a holistic, prevention-based model."
Northeast Missouri

"Somebody would notice the onset of my mental illness. (Mine occurred in college while living in a dorm and nobody noticed.)"
Anonymous

Strategy 1.2e: Adopt CDC guidelines for using tobacco settlement funds for tobacco cessation and other prevention services.

OBJECTIVE 1.3: INTEGRATE PUBLIC, PRIMARY AND MENTAL HEALTH CARE PRACTICES

Core Strategies:

Strategy 1.3a: Fully develop healthcare home concept and utilize healthcare home coordinator across primary and mental health service agencies.

Strategy 1.3b: Implement collaborative care practice model across primary care and mental health settings throughout the state.

Strategy 1.3c: Incorporate mental health risk indicators into health risk screenings across the lifespan.

Strategy 1.3d: Link mental health professional expertise with local health/public health offices to implement integrated public health promotion.

Strategy 1.3e: Integrate health promotion into community environments of people with developmental disabilities.

Strategy 1.3f: Implement collaborative planning, technical assistance, training and resources for disaster preparedness and emotional readiness for citizens and communities.

Strategy 1.3g: Cross-train health care providers in the care of adults, children and older adults with mental health needs including effective "cross-talk" between disciplines.

Strategy 1.3h: Utilize technologies to support integration of public, primary and mental health care practices.

"My mental health and physical health needs are being treated together and I know when one may be affecting the other. People understand that medication is only part of the solution."
Anonymous

"There would be help to get my teeth fixed so I have a healthy smile and strong jaws every day."
West Plains, MO

"My case documentation follows me to whatever state agency I contact. In other words, my medical and mental health care are well integrated. Agencies know who I am and what progress is made."
Anonymous

GOAL 2: MISSOURI MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN

OBJECTIVE 2.1:
INCREASE CONSUMER DECISION-MAKING AND SELF-DIRECTION OF AN INDIVIDUALIZED PLAN OF CARE.

Core Strategies:

Strategy 2.1a: Develop and implement consistent principles, processes, and framework for an individualized person-centered (or family-focused, youth-guided) plan of care across agencies and levels of care.

Strategy 2.1b: Implement children's "wrap-around" service practice to fidelity and develop equivalent philosophy and practice for adults and older adults.

Strategy 2.1c: Provide information, education and support to individuals in care and their families to enable them to fully participate in or direct their care and to assist and support each other.

Strategy 2.1d: Provide training to develop shared decision-making skills among individuals receiving care and their service providers.

Strategy 2.1e: Develop individual budgets for designated supportive services specified in individualized plans of care so that the total dollar value of the services is under the control and direction of the program participant.

Strategy 2.1f: Develop financial management service alternatives (e.g. support brokers, fiscal intermediaries) for consumers to assist with finances.

OBJECTIVE 2.2:
EXPAND AND INTEGRATE PEER AND FAMILY SUPPORT SERVICES INTO THE SYSTEM OF CARE.

Core Strategies:

Strategy 2.2a: Implement Peer Specialist training/certification program.

Strategy 2.2b: Implement training to support expansion of family support services.

Strategy 2.2c: Increase employment of peer and family support specialists in provider organizations.

Strategy 2.2d: Continue to build the evidence base for Consumer Operated Service Programs (COSPs) and other peer support services.

In a Community of Hope:

"Clinicians start with where people are and people have a say in their goals."
Southeast Missouri

"People receive the services they need, are in charge of what those services are and do not get turned away just because they don't have Medicaid."
Jefferson City, MO

"People (with mental illnesses) are able to pursue goals and dreams without being treated as if goals and dreams are for others."
Anonymous

"There would be places to make friends and support each other and learn how to support yourself and others…safe places to talk about your situation without fear of others judging you."
Anonymous

Strategy 2.2e: Expand peer and family education and support services in all provider and community settings, and adapt these programs to meet the needs of diverse communities.

Strategy 2.2f: Utilize a widely accessible web-based system for dissemination of training technologies.

OBJECTIVE 2.3:
CREATE A CULTURE OF RESPECT, DIGNITY & WELLNESS AS THE MILEAU IN WHICH ALL MENTAL HEALTH SERVICES ARE PROVIDED.

Core Strategies:

Strategy 2.3a: Incorporate consumers and family members in education and training programs to provide the perspective of the "lived experience" of mental health conditions and care.

Strategy 2.3b: Expand the Procovery demonstration pilot statewide.

Strategy 2.3c: Incorporate trauma-informed practice across all organizations including practices to reduce the use of restraints and seclusion in all levels of service.

Strategy 2.3d: Increase consumer knowledge and use of Psychiatric Advance Directives (PAD).

Strategy 2.3e: Develop a widely accessible web-based system for dissemination of training technologies usable by consumers, families and providers and further use of teleconferencing for providing training across provider networks.

OBJECTIVE 2.4:
INCREASE THE NUMBER OF CONSUMERS AND FAMILIES THAT FULLY PARTICIPATE IN THE DEVELOPMENT, IMPLEMENTATION AND EVALUATION OF THE SYSTEM

Core Strategies:

Strategy 2.4a: Provide training and develop peer and non-peer mentoring and other supports for consumers and families to effectively participate in policy development across the system.

Strategy 2.4b: Incorporate consumer and families across the lifespan into certification, monitoring and evaluation activities.

Strategy 2.4c: Create consistent policy and fiscal mechanisms to support consumer and family participation at all levels of the system.

"I have dignity and purpose. I will not fear the possibility of failure. State agencies support and empower us and we welcome agencies into our lives without reluctance."
Anonymous

"Labels do not represent the person."
Central Missouri

"Services would be very individualized and given because the person needed them. They would not be forced on them."
Southeast Missouri

"There would be Procovery circles!"
Southwest Missouri

"People get what they need with the expectation of recovery, self-sufficiency and contributing to the overall community and the next person who may need help."
Anonymous

GOAL 3: MENTAL HEALTH DISPARITIES ARE ELIMINATED IN MISSOURI

OBJECTIVE 3.1:

IMPROVE ACCESS TO QUALITY CARE IN RURAL AND GEOGRAPHICALLY REMOTE AREAS.

Core Strategies:

Strategy 3.1a: Establish geographic access standards and outcome measures and develop service, support and transportation alternatives in areas of state that do not meet standards.

Strategy 3.1b: Establish an equitable need-based method for allocating public sector mental health resources across the state.

Strategy 3.1c: Develop local system protocols to facilitate access to mental health services across geographic boundaries to meet needs when necessary.

Strategy 3.1d: Expand use of Missouri Telehealth Network to include more mental health locations and other healthcare locations to support service delivery, video conferencing, and educational/training sessions.

OBJECTIVE 3.2:

IMPROVE ACCESS TO CULTURALLY COMPETENT CARE

Core Strategies:

Strategy 3.2a: Develop, implement and evaluate a statewide plan for cultural and linguistic competency linking existing plans and initiatives.

Strategy 3.2b: Provide training and disseminate standards and tools for culturally competent practice.

Strategy 3.2c: Create workplace environments that are conducive to a diverse workforce.

Strategy 3.2d: Provide educational and performance incentives for professionals proficient in American Sign and non-English languages.

Strategy 3.2e: Expand Missouri Tele-health and other technologies to reduce access disparities.

In a Community of Hope:

"I would be able to get quality services, close to where I live, when I need them…not when I qualify for them. I wouldn't have to drive 100 miles to find a provider."
Trenton, MO

"Everyone has access to appropriate, individualized services regardless of where they live, what they look like or how much money or insurance they have."
Anonymous

"There would be an array of culturally and linguistically appropriate services and community supports available with better insurance and Medicaid coverage for professionals fluent in sign language, etc."
St. Joseph, MO

"All clients would be served without bias. Also, they would not have to quit their job to qualify for Medicaid."
Kirksville, MO

OBJECTIVE 3.3:
INCREASE CONSUMER ACCESS TO PROGRESSIVE EMPLOYMENT OPPORTUNITIES IN INTEGRATED COMMUNITY SETTINGS.

Core Strategies:

Strategy 3.3a: Issue a policy directive that employment and economic engagement is a Missouri priority as one step out of poverty.

Strategy 3.3b: Provide evidence-based supported employment services with relevant benchmarks for increasing employment.

Strategy 3.3c: Provide benefits counseling to Missourians receiving mental health services as they pursue employment. Highlight mechanisms for continued mental health services and related supports as these persons obtain employment.

Strategy 3.3d: Develop partnerships with employers, agencies and other stakeholders to promote employment and self-sufficiency.

Strategy 3.3e: Promote and develop consumer involvement as mentors, role models and professionals in behavioral health services.

Strategy 3.3f: Use web-based technology to provide training.

"Employment is rewarded instead of being a negative consequence for persons seeking it."
Kansas City, MO

"Recovery is not a penalty in private insurance."
St. Louis, MO

"I would have support in building a life, finding a home and finding a job—not just working but finding work that I am capable of and enjoy."
Anonymous

OBJECTIVE 3.4:
INCREASE CONSUMER ACCESS TO SAFE AND AFFORDABLE HOUSING IN INTEGRATED COMMUNITY SETTINGS.

Core Strategies:

Strategy 3.4a: Develop or enhance local housing collaboratives to increase the development of safe, affordable housing for people with mental health needs/disabilities in their communities.

Strategy 3.4b: Provide ongoing technical assistance and expertise to developers and community partners to plan projects and identify/obtain funding sources, maximizing all federal dollars available.

Strategy 3.4c: Expand supported housing service options to support people with mental health needs in independent or semi-independent housing.

Strategy 3.4d: Utilize web-based technology to disseminate training and affordable housing information.

"I would have opportunities for an income and housing. I would no longer be homeless."
Hayti, MO

"Residential (facilities) inspire hope. There are areas for interaction. There is daily living without stigma. There is one main Center of Support to help with problems/needs."
Malden, MO

GOAL 4: EARLY SCREENING, ASSESSMENT AND REFERRAL TO CARE IS COMMON PRACTICE IN MISSOURI

OBJECTIVE 4.1:
PROVIDE TIMELY OUTREACH, SCREENING AND REFERRAL TO CARE THAT IS AGE AND CULTURALLY APPROPRIATE.

Core Strategies:

Strategy 4.1a*: Establish* a "one door" philosophy and practice using standardized screening tools and seamless referral protocols across local providers.

Strategy 4.1b: Develop common eligibility standards and means testing across state agencies and a shared information system.

Strategy 4.1c: Train and utilize non-mental health professionals and natural helpers to provide mental health outreach /screening to targeted populations.

Strategy 4.1d: Provide professional outreach and investigation services to engage and assist people in accessing appropriate care.

Strategy 4.1e: Expand Police Crisis Intervention Teams (CITs) and Mental Health Courts for screening/ jail diversion statewide. Work in partnership with Chief Justice initiative.

Strategy 4.1f: Identify and remove barriers to voluntary admission and/or outpatient commitment as alternatives to inpatient commitment when appropriate.

Strategy 4.1g: Expand current mobile crisis capacity to allow for non-emergency screening and assessment to targeted groups when indicated.

Strategy 4.1h: Establish functional/behavioral criteria to access services versus diagnosis where appropriate.

Strategy 4.1i: Establish a single identifier and virtual (web-based) single point of entry for all agencies\providers.

Strategy 4.1j: Develop screening and assessment protocols specific to late onset mental illnesses in older adults.

OBJECTIVE 4.2:
PROVIDE MENTAL HEALTH CONSULTATION AND SERVICES IN EARLY CHILDHOOD AND SCHOOL SETTINGS.

Core Strategies:

Strategy 4.2a: Support and develop Missouri school-based mental health model to bring to scale.

In a Community of Hope:

"There are no barriers to getting treatment. There is one-stop access to services."
St. Louis, MO

"The door for HELP is always open and only the 'can do' attitude is ever considered. Dreams and hard work are turned into reality. "
Farmington, MO

"I would be able to get services before I try to commit suicide and need to be hospitalized. I would not have to wait for months before I 'qualify' for services. People would be able to get help before they lose 'everything'."
Camdenton, MO

"Uninsured college students studying in Missouri could receive medical help and psychiatric care when needed."
Springfield, MO

"My child receives education with care and knowledge for her to stay in school."
St. Joseph, MO

"Children in rural schools who are at risk receive mental health counseling through the schools."
Louisiana, MO

Strategy 4.2b: Support the Bright Futures interagency effort to enhance community capacity to map assets and needs and increase interagency support for improved child outcomes.

Strategy 4.2c: Develop guidelines for the formation/expansion of community response teams linked with local school districts.

Strategy 4.2d: Coordinate system development efforts for improved mental health services in early childhood with the Coordinating Board for Early Childhood Services.

Strategy 4.2e: Develop and support strategies to increase community and provider knowledge related to infant/toddler/child mental health.

OBJECTIVE 4.3:

EXPAND COMMUNITY CAPACITY TO REDUCE AVOIDABLE USE OF EMERGENCY ROOMS, HOSPITALS AND OTHER INSTITUTIONAL CARE.

Core Strategies:

Strategy 4.3a: Build capacity for early intervention and access to community-based care.

Strategy 4.3c: Develop "Continuing Care" options linked with peer supports and integrated health/mental health services.

Strategy 4.3d: Expand evidence-based services that are designed to support people in community settings including integrated dual diagnosis treatment services (IDDT) across state.

Strategy 43e: Develop system to identify high- users of services with poor outcomes and develop/implement and evaluate cross-agency practice model to improve outcomes.

Strategy 4.3f: Assess efficacy of services for children with SED and identify service and system needs to improve outcomes for children.

Strategy 4.3g: Create incentives to expedite eligibility and support home and community-based services, when appropriate.

"There would be mental health support for my son when he is in school, I am at work, and he is having a bad day or trouble with complying."
Anonymous

"People would be able to move quickly through the continuum of care."
Fulton, MO

"Everyone will be able to live with dignity and be free of the fear that they could lose everything because of a crisis."
St. Louis, MO

"There is no fear of improving just enough to lose my services and then needing them again."
Camdenton, MO

"The way out of the system is always visible."
Anonymous

GOAL 5: EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND RESEARCH IS ACCELERATED

OBJECTIVE 5.1:
DEVELOP THE MENTAL HEALTH WORKFORCE

Core Strategies:

Strategy 5.1a: Assess mental health workforce needs in Missouri and develop comprehensive workforce development plan.

Strategy 5.12b: Identify core and focused competencies for the mental health workforce and implement competency-based curriculum.

Strategy 5.1c: Incorporate person-centered, culturally competent and trauma-informed principles into all curriculums for older adults, adults, youth and children.

Strategy 5.1d: Develop and implement systematic recruitment and retention strategies inclusive of wages and benefits commensurate with capabilities.

Strategy 5.1e: Enhance the infrastructure available to support and coordinate workforce development efforts by establishing integrated funding mechanisms to support workforce enhancements across systems.

Strategy 5.1f: Develop e-learning platform to provide training.

OBJECTIVE 5.2:
EXPAND EVIDENCE-BASED PRACTICES (EBPS) ACROSS THE STATE.

Core Strategies:

Strategy 5.2a: Adopt a common definition of EBPs and a "balanced portfolio" approach to selecting EBPs and targeting resources.

Strategy 5.2b: Implement an incremental needs-driven approach to add evidence-based prevention, early intervention and treatment services on a regular basis that includes fidelity assessment.

Strategy 5.2c: Develop provider financing incentives to support EBP development and practice to include new funding, pay for performance incentives, and funding for training, development, and evaluation.

Strategy 5.2d: Develop a system allowing consumer choice of providers certified in an EBP by DMH, without regard to geographic/service area to insure universal availability.

Strategy 5.2e: Develop policy statement that ensures broad-based consumer and family input into EBP selection and funding.

In a Community of Hope:

"We value substantive training that makes a professional good but also invest resources that make them great."
Anonymous

"Agencies are given the necessary tools to assist people in pursuing their dreams."
Anonymous

"There are incentives for people to pursue career opportunities in mental health such as scholarship opportunities for psychiatry degrees, good pay for staff and employee assistance for mental health professionals to prevent burnout and career change."
Anonymous

"Government resources are used to support treatment that works. The resources are balanced to support known evidence based practice, promising practices and support the people who do the work."
Anonymous

"People with both

OBJECTIVE 5.3:
APPLY RESEARCH EVIDENCE MORE QUICKLY AND INVEST IN RESEARCH FOR NEW AND PROMISING PRACTICES.

Core Strategies:

Strategy 5.3a: Incorporate EBP into university formal education curriculum and training/internship opportunities.

Strategy 5.3b: Create a collaborative technical assistance infrastructure (i.e. "Coordinating Centers of Excellence") to provide technical assistance, conduct evaluation and research, and disseminate new research findings.

Strategy 5.3c: Create a training curricula and implementation process for EBP core competency development using multiple modalities for education and mentoring.

Strategy 5.3d: Develop education and licensure incentives for continuing education in evidence-based practices adopted by Missouri.

Strategy 5.3e: Educate consumers and families about EBPs that promote resiliency, recovery and self-determination and involve them in the development and implementation of on-going education activities.

OBJECTIVE 5.4:
DEVELOP A COMPREHENSIVE QUALITY MANAGEMENT SYSTEM

Core Strategies:

Strategy 5.4a: Adopt common/unique identifier and/or effective crosswalk for consumers across state agencies.

Strategy 5.4b: Develop a statewide data warehouse and information system to track services and support a dynamic system of outcomes across agencies/organizations.

Strategy 5.4c: Develop key population, system and individual outcome measures and performance indicators.

Strategy 5.4d: Phase in the cross-agency quality service review process throughout the children's system of care and review for adaptation to adult and older adult system.

Strategy 5.4e: Develop an accessible information system for providing quality information about services and providers.

developmental disabilities and mental illnesses see people who understand both of their needs."
Anonymous

"Medications are seen as a tool to be used as part of a continuum of care, and not to be used when they are ineffective or no longer needed."
Camdenton, MO

"There is evidence-based practice as well as practice-based evidence. "
Anonymous

"Service providers are accountable to consumers for the quality and effectiveness of their services."
St. Louis, MO

"Consumers have easy access (e.g. internet) to information about the quality and cost of services. Providers would be committed to continuing education that could be accessed 24/7."
St. Louis, MO

GOAL 6: MISSOURI COMMUNITIES ARE PROFICIENT IN MEETING LOCAL MENTAL HEALTH NEEDS

OBJECTIVE 6.1:
CREATE CONSISTENT & FLEXIBLE POLICY/PRACTICES ACROSS STATE AGENCIES THAT ARE INFORMED BY CONSUMERS & LOCAL NEEDS.

Core Strategies:

Strategy 6.1a: Establish enduring state cross-departmental structure at the operations level to maximize funding, set policy, and coordinate activities. Enhance DMH leadership role to ensure consistent mental health policy and practice across agencies.

Strategy 6.1b: Establish leadership structure for consumer/family input to state mental health policy and budget decisions ***across*** state departments.

Strategy 6.1c: Develop and adopt a shared service philosophy and common practice model across systems for transitional youth, adults and older adults building on children's comprehensive system model.

Strategy 6.1d: Create more consistent regions/service areas across public agencies.

Strategy 6.1e: Incorporate parity for substance abuse treatment into current mental health parity legislation.

Strategy 6.1f: Develop flexible funding alternatives (e.g. blending or braiding funding) to assure non categorical service capacity.

OBJECTIVE 6.2:
CREATE AND/OR EXPAND LOCAL PUBLIC-PRIVATE COLLABORATIVES TO IMPROVE SERVICE ACCESS, CAPACITY & INTEGRATION.

Core Strategies:

Strategy 6.2a: Establish regional health and mental health planning partnerships that work with local systems and communities to prioritize and formulate solutions to meet local needs and eliminate fragmentation across local agencies.

Strategy 6.2b: Expand local systems of care for children implementing an area management structure to meet the needs of communities and families that are adaptable to geographic and cultural differences.
Strategy 6.2c: Develop incentives and partnerships to increase local investment in mental health including local county funding initiatives.

Strategy 6.2d: Develop/expand consumer, family and provider access to a comprehensive information system(s) that provide information about services received across providers.

In a Community of Hope:

"State agencies are on the same page in support of the client. People do not fall through the cracks."
Steeleville, MO

"The focus is on trying to take care of the problem, not trying to decide on which department or division should fund the service."
Anonymous

"There is ongoing communication between the state facilities and community providers to better serve consumers."
St. Louis, MO

"The system would be simplified with a common language when a client goes from one level of care or location to another so that it doesn't feel like you are traveling to another country."
Anonymous

"Agencies forgo artificial turfs and unselfishly put clients first."
Southeast Missouri

OBJECTIVE 6.3:
EXPAND THE ROLE AND CAPACITY OF COMMUNITIES TO IDENTIFY THEIR NEEDS, PROMOTE MENTAL HEALTH AND CREATE OPPORTUNITIES FOR CONSUMER INCLUSION.

Core Strategies:

Strategy 6.3a: Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.

Strategy 6.3b: Strengthen existing connections between mental health organizations and their local communities.

Strategy 6.3c: Phase in statewide community assessment process to determine risk and protective factors, incidence and prevalence; risk levels among populations; available resources; and community readiness for change.

"Schools, mental health agencies, community organizations, justice system, etc. would all work together with clients/families."
Springfield, MO

"Providers communicate with each other as well as with the client or family to meet their needs."
St. Joseph, MO

"Treatment and prevention succeed because the community is vested in the success of the customer."
St. Louis, MO

"People come together wanting to learn more about mental health and helping others. There is more information available."
Hannibal MO

Part 3: Initial Action Plan

Overview

Priority actions for 2008 were identified to address the goals, objectives and core strategies in Part 3 of this plan. A separate chapter was developed for three reasons:

- Several actions address multiple objectives and strategies.
- Due to the dynamic nature of the transformation Initiative, the Action Plan will be updated regularly to reflect the current priorities and efforts. This will allow the TWG to capture new opportunities, add or modify actions as more detailed implementation plans are developed and "course correct" as necessary to meet broader goals.
- Annual updates can readily be addressed through a separate plan "Supplement" document without changing the entire plan. The supplement can serve as an annual report that outlines progress, significant updates and an updated Action Plan for the following year.

The Action Plan outlined on the following pages begins with a legend explaining the plan detail. Actions are descriptive and purposefully broad. Timelines reflect the estimated start date of the entire project. As the actions plan will be evaluated using prescribed measures from SAMHSA, preliminary measures have been listed for applicable goals. The evaluation team will develop more detailed measures as implementation begins. Given the scope of the plan, a decision was made to include significant actions that are directly linked with core strategies even if they are funded and evaluated through alternative grants or contracts. Therefore, SAMHSA measures will not be applied to all actions. At the same time, the actions described in this section are by no means inclusive. For example, the implementation of several different evidence-based practices are underway, yet not listed at this time. The TWG recognizes and appreciates the multiple initiatives under way across the state in support of this plan.

Legend of Abbreviations used in Action Plan

ACE Goals-measures of anticipated long-term impact
A-Improved Accountability
C- Increased Service Capacity
E-Increased Service Effectiveness

GPRA Goal-measures of infrastructure changes completed:
1= Policy Changes Completed
2= # of Persons in Workforce Trained
3= Financing Policy Changes Completed
4= Organizational Changes Completed
5= # of Organizations that Regularly Obtain and Analyze Data
6= # of Members in Consumer and Family Run Networks
7= Programs Implementing Practices Consistent with CMHP
8= Separate Evaluation Process
9= To Be Determined

Target Populations:
Persons served across agencies and/or systems who are at risk for or experiencing:
- MI = Mental illness
- ADA = Addictions
- DD = Developmental Disabilities

Note: This also covers the general public and service providers.

Age Group:
- CY&F = Children, Youth and Families
- A = Adults
- OA = Older Adults

Complexity of Implementation:
Low = action will be completed with ease during established timeframes
Medium = major components of action will be realistically achieved over course of plan timeframe/grant period resulting in significant progress to achieving overall objective
High = Action will require multiple years that will likely extend beyond plan timeframe

Time Frames:

//////////////////////	Start-up Planning
	Implementation
<	Implementation initiated prior to 2008
>	Implementation anticipated to continue beyond 2008

Acronyms Used:
AAA - Area Agency on Aging
ADA - Division of Alcohol and Drug Abuse
CPS - Division of Comprehensive Psychiatric Services
CSMT - Comprehensive System Management Team
DESE - Department of Elementary and Secondary Education
DHSS - Department of Health and Senior Services
DMH - Department of Mental Health
DPS - Department of Public Safety
DSS - Department of Social Services
EBP - Evidence Based Practices
MACDDS – Missouri Association of County Developmental Disabilities Services
MARF-Missouri Association of Rehabilitation Facilities
MHFA - Mental Health First Aid
MO-ACEs - Missouri Autism Centers for Excellence
MO-ANCOR—Missouri Chapter of the American Network of Community Options and Resources
MIMH – Missouri Institute of Mental Health
MPC - Missouri Planning Council
MRDD - Division of Mental Retardation and Developmental Disabilities
OCCMH - Office of Comprehensive Child Mental Health
OOA - Office of Administration
OOT - Office of Transformation
PACs - Parent Advisory Council
SLRHC - St. Louis Regional Health Commission
TWG - Transformation Working Group
UMKC—University of Missouri—Kansas
UMKC IHD—UMKC Institute for Human Development

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
1.1 1.2	**Mental Health Promotion and Public Education Workgroup:** Charter cross-departmental workgroup to guide the development and implementation of anti-stigma/public information campaign. • Establish subcommittees to advise and direct on key actions and initiatives • Establish small workgroup to meet with existing groups, i.e. Missouri Prevention Partners and other groups, at state level to identify related prevention actions and explore potential for partnerships. **Initial Target Population:** **MI** **DD** **ADA** **ALL** √ **CY&F** **ADULT** **OA** **ALL** √	**TWG**	**C E**	**9**	**Medium**												v
1.1 2.3	**Respect Seminars & Institute:** • Provide statewide training and organizational consultation to build culture of respect. • Initiate training of consumers and families through two 4 day Respect Institutes. • Begin development of Peer Speakers Bureau in Missouri as component of public information campaign in partnership with advocacy organizations. • Link with public education/anti-stigma activities. **Initial Target Population:** **MI** **DD** **ADA** **ALL** √ **CY&F** **ADULT** **OA** **ALL** √	**DMH OOT& Public Education and Prevention Workgroup**	**C E**	**2**	**Medium**												v

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
1.1 1.3 5.3	**Mental Health First Aid**: • Implement evidence-based 12-hour mental health literacy training program as part of public education campaign. • Work with state of Maryland and SAMHSA to convert training curricula and certification standards for use in United States. Train initial cohort of trainers. • Identify populations and begin training. • Identify and apply for match funding to expand training. • Develop business plan for long term sustainability. **Initial Target Population:** MI √ / DD / ADA √ / ALL CY&F / ADULT / OA / ALL √	DMH OOT & Public Education and Prevention Workgroup	C E	2	Medium												v
1.1 2.3 3.2 5.1	**Reducing Stigma and Increasing Cultural Competency Pilot:** • Conduct pilot training program in eastern region to change current culture of health care system by addressing barriers to quality care related to stigma and cultural competency. Initial 1½ day cross-agency training targeted for April with 3 planned follow-ups. Respect Seminars will be combined with Cultural competency curricula. • Evaluation will guide state-wide expansion in year 2 in partnership with MO Coalition of CMHC's. **Note:** Agencies involved serve persons of all ages. **Initial Target Population:** MI √ / DD / ADA √ / ALL CY&F / ADULT / OA / ALL √	SLRHC Behavioral Health Steering Team & Workgroup DMH OOT & Divisions of CPS and ADA	A C E	7	Medium												

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1.1	**Mental Health Foundation:** • Develop public-private partnership to establish permanent Missouri Mental Health Foundation that supports public education, stigma reduction and consumer empowerment initiatives. • Identify potential fundraisers and contributors to foundation and implement for long term success and sustainability of fund projects. **Initial Target Population:** MI | DD | ADA | ALL √ CY&F | ADULT | OLDER ADULT | ALL √	DMH & Midwest Special Needs Trust	C	3	Medium	<											>
1.1	**Network of Care:** • Designate an internal contact and project lead in the Divisions of Comprehensive Services and Mental Retardation/ Developmental Disabilities. • Establish work plan and measurable outcomes in terms of NoC usage, updated resource information, expanded transparency and safety promotion. • Share all NoC information with Missouri 211 system for inclusion in information and referral services of that system. **Initial Target Population:** MI √ | DD √ | ADA | ALL CY&F | ADULT | OA | ALL √	DMH – Director's Office, Divisions of CPS & MRDD	C	9	Medium												
1.1	**Transformation Communications and Accountability Plan:** • Design enhanced Mental Health Transformation website. • Produce regular briefings on key issues, successes and progress through prepared media releases, newsletters and other communications • Produce annual report. **Initial Target Population:** MI | DD | ADA | ALL √ CY&F | ADULT | OA | ALL √	DMH OOT	A	9	Medium												>

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
1.2	**Suicide Prevention E-Learning:** • Finalize the content/design of a graduate level course in suicide prevention; make available online for academic credit. • Identify 5 content areas for one-hour modules of suicide prevention. information including: Risk & Protective Factors; Warning Signs & Action Steps; Suicide Statistics for Missouri; Stigma & Suicide; Suicide & Attempted Suicide in Adolescents. Make these modules available on line for ease of access. **Initial Target Population:** **MI** | **DD** | **ADA** | **ALL** √ **CY&F** | **ADULT** | **OA** | **ALL** √	**DMH, DHSS & University of Missouri**	C	9	**Low**												
1.2	**Suicide Prevention Elderly Pilot:** • Identify a geographical area for the pilot program with a Suicide Prevention Resource Center and an AAA willing to work together and a CMHC with capacity to meet referral needs. • The Suicide Prevention Resource Center will offer suicide prevention training to individuals designated by the AAA to include drivers for Meals on Wheels, home health aides, companions, AAA staff, families and friends and spouses, interested community members. • Referrals and results will be documented by those trained to inform the evaluation, identify lessons learned, and ensure help is activated in response to need. **Initial Target Population:** **MI** | **DD** | **ADA** | **ALL** √ **CY&F** | **ADULT** | **OA** √ | **ALL**	**DMH, DHSS & Northwest AAA**	**C E**	**7**	**Medium**													v
1.2	**NO BUTTS About It:** • Assess tobacco usage by consumers of mental health services. • Develop a plan to prevent tobacco use. by consumers of mental health services • Seek implementation funding. **Initial Target Population:** **MI** | **DD** | **ADA** | **ALL** √ **CY&F** | **ADULT** | **OA** | **ALL** √	**DMH & DHSS**	C	7	**Medium/ Low**												

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
1.1 1.2 1.3 4.2 6.2	**Higher Education Mental Health Homeland Security Initiative:** Foster collaborative relationships on college campuses across the state to implement recommendations to involve mental health expertise in emergency planning for campuses; • Education/training on how to access 24/7 mental health services by campus authorities and students, either CMHCs and/or on campus expertise; • Education/training on linkages for activating civil commitment if needed. • Investigate applicability of MHFA training for campus personnel and students **Initial Target Population:** **MI** | **DD** | **ADA** | **ALL** √ **CY&F** | **ADULT** √ | **OA** | **ALL**	**Homeland Security Taskforce, Department of Higher Education and Public Safety Subcommittee** **DMH Directors Office**	**C**	**9**	**Medium**												
1.3 4.3 6.2	**Disaster Services and Special Needs Shelters:** • DMH disaster services staff will participate in Bi-monthly meetings. • Provide input and updates regarding special needs shelters for State Emergency Operations Plan Annex X and Annex X Appendix. • Create template for local public health authorities and emergency operations centers to request mental health .assistance for activated special needs shelters. **Initial Target Population:** **MI** | **DD** | **ADA** | **ALL** √ **CY&F** | **ADULT** | **OA** | **ALL** √	**Special Needs Committee DHSS DMH**	**C**	**9**	**Medium**												
1.3	**CMHC-FQHC Collaborative Care Pilot:** Pilot 7 collaborative care pilots between federally qualified health centers (FQHC's) and community mental health centers (CMHC's). Evaluation will guide needed policy changes and additional expansion. **Initial Target Population:** **MI** √ | **DD** | **ADA** √ | **ALL** **CY&F** | **ADULT** | **OA** | **ALL** √	**DMH Division of CPS, Missouri Coalition of CMHC's, Missouri Primary Care Association**	C E	**8**	**Medium**												v

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
1.3	**Integration of Mental Health to Health Care Home Model (DMH NET):** ▪ Establish guidelines for Community Mental Health Centers to serve as health care homes for individuals with serious mental illness under the MO HealthNet Plan; • Provide disease management services for Medicaid-eligible individuals with mental illness and co-occurring physical health conditions; and • Provide data analysis and educational materials to health care providers regarding good psychiatric prescribing practices. **Initial Target Population:** **MI** √ / **DD** / **ADA** / **ALL** **CY&F** / **ADULT** / **OA** / **ALL** √	**DMH & DSS Division of MO HealthNet**	**A E**	**4**	**Medium**	<											>
2.1 2.3 2.4	**Person-Centered Planning:** Enhance Person Centered Planning within the Division of MRDD and implement Person Centered Planning principles and process within the CPS provider system. • Issue a policy affirming person centered values as the foundation for the entire mental health services system. • Conduct training for all staff including administration and direct support on person centered thinking/philosophy, following by training on person centered planning. • Provide access to mentors to facilitate person centered planning and implementation of plans. **Initial Target Population:** **MI** √ / **DD** √ / **ADA** / **ALL** **CY&F** / **ADULT** / **OA** / **ALL** √	**DMH Divisions of MRDD and CPS and UMKC Institute for Human Development**	**E**	**2**	**High**												>

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
2.1	**Self-Directed Supports and Services:** • MRDD Waivers amended to add options for self-directed and family directed services. • Secure a fiscal management service contractor to provide a wide range of fiscal support services to enable more people to self-direct • Training to be provided to service coordinators, consumers and families regarding choices, risks and benefits. • Explore methods to expand self-directed options to other services **Initial Target Population:** MI: DD √; ADA; ALL CY&F; ADULT; OA; ALL √	DMH Division of MRDD, Missouri DD Planning Council & UMKC IHD	E	3	Medium	<											>
2.1	**Consumer Principles for Practice Workgroup:** Charter short-term work group to review The "Practice Guidelines for Consumer Directed Services and Supports" developed in 2002 by DMH. These will be reviewed by all State agencies that provide human services, with the goal of adoption as appropriate to the population(s) served. **Initial Target Population:** MI; DD; ADA; ALL √ CY&F; ADULT; OA; ALL √	TWG	E	9	Low												
2.1 6.1	**Wrap-Around Fidelity:** The CSMT is working to identify wraparound values/principles that all state child serving departments can endorse. Certified wraparound facilitators are members of the committee working on this issue. Once values/principles are developed and endorsed, departments will identify system and infrastructure changes necessary to support them. Missouri's ultimate goal is that high fidelity wraparound will be used by all public agencies with ongoing training needs met through the use of in-state certified trainers. **Initial Target Population:** MI √; DD; ADA; ALL CY&F √; ADULT; OA; ALL	DMH OCCMH & CSMT	E	2	Medium												>

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
2.2	**Peer Specialists Training and Certification:** Train primary consumers to provide direct services within the CPS provider network. using training and certification model l developed by Larry Frick/ Appalachia Consulting for the State of Georgia. Train 40 consumers this fiscal year Develop two (2) Missouri trainers to continue annual training. Review rules, regulations and certification standards and modify or develop new rules as needed. **Initial Target Population:** MI √ / DD / ADA / ALL CY&F / ADULT √ / OA / ALL	DMH Division of CPS and OOT	C E	2	Medium												
2.2	**Family Support Training:** Finalize curriculum and initiate state wide training to provide participants including parents of children with mental illness the core competencies and skills sets to become a Family Support Provider within the comprehensive children's mental health system. Participants will be required to complete a competency test prior to billing for services. Identify policy or financing changes required to support employment of trainees. **Initial Target Population:** MI √ / DD / ADA / ALL CY&F √ / ADULT / OA / ALL	DMH OCCMH & Division of CPS	C	2	Medium												

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
2.2	**Consumer Operated Service Program (COSP) Quality Improvement Initiative:** Initiate phase two of COSP Quality improvement initiative that provides training for self-assessment of fidelity. The "drop-in" programs are piloting a SAMHSA-funded EBP toolkit. All programs have received a fidelity visit to establish baseline. Phase 2 includes: • Fidelity follow-up visits will be made to two (2) of the five (5) programs. All programs are receiving instructions on how to self-administer the fidelity tool. • Modify fidelity tool to use with telephone support lines and initiate baseline reviews. **Initial Target Population:** MI √ / DD / ADA / ALL CY&F / ADULT √ / OA √ / ALL	DMH Division of CPS, MIMH	A E	7	Medium	<											>
2.3	**Procovery State-wide Expansion:** Begin state-wide implementation of Procovery program. Infrastructure put in place over past year to prepare for state-wide expansion included organizational and individual licensure process, data management structure and staff support. In 2008: • Conduct 4 general trainings and follow-up facilitator trainings beginning April. • Implement facilitator support to add new Procovery circles. • Establish second phase evaluation to include one article submitted /published in peer review journal. **Initial Target Population:** MI / DD / ADA / ALL √ CY&F / ADULT / OA / ALL √	DMH Division of CPS & OOT	C E	2	Medium												
2.2	**Peer and Family Mentoring:** Expand access to peer and family mentoring through Sharing our Strengths. **Initial Target Population:** MI / DD / ADA / ALL √ CY&F / ADULT / OA / ALL √	DMH- MRDD & UMKC Institute for Human Development	C	9	Medium												

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
2.3 5.1 5.2	**Positive Behavioral Support Training:** • Develop a certification process for trainers of PBS to increase expertise and capacity at the local level. • Utilize certified trainers to expand knowledge of the principals and practices of positive behavior supports. • Explore expansion of positive behavior supports principals and populations to other target groups and systems of care. **Initial Target Population:** MI √ / DD √ / ADA / ALL CY&F / ADULT / OA / ALL √	DMH Division of MRDD	C E	2	Medium												
2.4 5.4	**Peer and Family Participation in Certification, Monitoring and Quality Service Reviews:** • Implement guidelines developed by CPS State Advisory Council to include peers and family members in the monitoring and certification of CPS funded community-based programs. • Provide additional family training for participation in Quality Service Reviews (QSR) conducted at local system of care sites for children. • Continue implementation of quality of life surveys conducted by self-advocates and families for people transitioning from institutions and receiving community-based services. **Initial Target Population:** MI √ / DD √ / ADA / ALL CY&F / ADULT / OA / ALL √	DMH Division of CPS DMH OCCMH & CSMT DMH Division of MRDD	A E	4	Medium												

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
2.4	**Consumer, Family and Youth Leadership Training:** Workshops will be held to engage emerging leaders by taking a journey through the process of telling their stories to becoming leaders who promote systems change. Participants explore the difference between advocacy and leadership and when to use the different approaches. The workshop provides examples of the supports that may be needed for participants to participate on teams and committees. **Initial Target Population:** **MI** | **DD** | **ADA** | **ALL** √ **CY&F** | **ADULT** | **OA** | **ALL** √	DMH OOT	E	9	Low to Medium												
3.1 3.2 4.3 5.1	**Capacity Development Analysis:** Using information contained in Needs Assessment and Inventory of resources, conduct system capacity analysis. • Identify required service array inclusive of peer and family support and education service across continuum based upon prevalence, identified need and review of available evidence. • Perform gap analysis of need and resources to include gaps related to culture, geography and age. • Develop appropriate criteria to identify true waitlist for services consistent with model used by MRDD division. Project scope will be phased over next two years. **Initial Target Population:** **MI** | **DD** | **ADA** | **ALL** √ **CY&F** | **ADULT** | **OA** | **ALL** √	DMH OOT	C E	9	Medium to High												

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3.1 4.3	**Telehealth:** • Pilot the delivery of behavior therapy and crisis intervention using telehealth equipment, and evaluate results. • Amend MRDD waivers to include telehealth as a venue for service delivery. **Initial Target Population:** MI: DD √; ADA; ALL CY&F; ADULT; OA; ALL √	**DMH Division of MRDD**	C	9	Low	<											>
3.3	**Employment Workgroup:** **C**harter workgroup to begin implementation of employment strategies. Review current state rules, regulations and financing policies and recommend revisions as appropriate to increase consumer employment and financial independence without losing necessary services and supports. **Initial Target Population:** MI; DD; ADA; ALL √ CY&F; ADULT; OA; ALL √	**TWG**	C	9	Medium												
3.4	**Housing Workgroup:** **C**harter workgroup to identify current resources and gaps in affordable and integrated housing and begin implementing housing strategies. Review current state rules, regulations and financing policies and recommend revisions as appropriate to increase consumer access to an array of housing options for persons with disabilities. **Initial Target Population:** MI; DD; ADA; ALL √ CY&F; ADULT; OA; ALL √	**TWG**	A C	9	Medium												
3.4	**Housing Registry:** Develop a housing resource, which will include a registry of affordable, accessible, integrated housing in Missouri, as well as resources to rent, buy, or modify a home of one's own. **Initial Target Population:** MI; DD; ADA; ALL √ CY&F; ADULT; OA; ALL √	**DMH Division of MRDD & MPC**	C	9	Medium	<											>

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3.2	**Deaf Services Capacity Development:** Re-evaluate the state's current plans and services for individuals who are deaf and have mental health needs based on best practices in other states and consistent with culturally distinct needs of the deaf community. Principles and strategies to be explored include use of technology to create a virtual statewide highly-specialized and cross-discipline technical assistance team, service navigators as a support for deaf consumers, categorical eligibility to support early intervention service to deaf individuals and their families, cross-departmental integration of services and data analytics to improve the system's ability to identify interventions with the greatest benefit to the most individuals. **Initial Target Population:** MI: DD: ADA: ALL √ CY&F: ADULT: OA: ALL √	DMH Office of Director	A C E	9	Medium-High												
3.2	**Language Translation:** Develop translation for DMH web content, brochures and other and informational materials. Partner with local groups to assist in translating materials. Initial priority is Spanish translation. Phase 2 priorities are ASL and Bosnian translation. **Initial Target Population:** MI: DD: ADA: ALL √ CY&F: ADULT: OA: ALL √	DMH Office of Director	C	9	Medium												
4.1	**Improving Entry Pilot:** Develop and pilot a standardized screening tool and referral protocols across mental health and substance abuse providers in Eastern region. Evaluation will guide further refinement and potential for state-wide expansion. **Initial Target Population:** MI √: DD: ADA √: ALL CY&F: ADULT √: OA √: ALL	SLRHC Behavioral Health Steering Team DMH OOT & Divisions of CPS and ADA	A E	4	Medium												

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4.1	**Mental Health Coordinator Legislation Change:** Propose legislative change to allow private mental health providers to be designated to perform outreach and investigative procedures as a component of the access-crisis intervention functions to facilitate assessments of need for services including need for involuntary commitment. **Initial Target Population:** MI / DD / ADA / ALL √ CY&F / ADULT / OA / ALL √	DMH Division of CPS	A C	1	Medium												
4.1	**State-wide Expansion of Police Crisis Intervention Teams (CIT):** Establish contracted state-wide coordinator position to staff steering group to develop and implement CIT state-wide in partnership with Chief Justice initiative. Develop rural adaptations to existing model. **Initial Target Population:** MI √ / DD / ADA / ALL CY&F / ADULT / OA / ALL √	DMH Division of CPS, Chief Justice Initiative	C E	4	Medium-High												
4.3 6.2	**Psychiatric Acute Care Transformation (PACT):** • Identify potential regional partnerships with community general hospitals and community providers of psychiatric services to determine if there are options for providing acute inpatient psychiatric care to DMH consumers by non-state operated providers • Ensure the continued availability of acute psychiatric inpatient beds on both a state-wide and regional basis, while improving access to both inpatient and outpatient services and enhancing the dollars available for operating the entire continuum of psychiatric care. **Initial Target Population:** MI √ / DD / ADA / ALL CY&F / ADULT √ / OA √ / ALL	DMH Division of CPS	C	9	High												v

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1.3 4.1	**SBIRT:** To identify individuals in the early stages of substance abuse, ADA will implement Screening, Brief Intervention and Referral to Treatment for individuals presenting at emergency rooms in Springfield and St. Joseph. (Note: Pending funding mechanisms w/Medicaid). **Initial Target Population:** MI: ADA √ CY&F: ADULT √; OA √	DMH Division of ADA	A E	8	Medium to High												
4.3	**Coordinating Care for High Utilizers Pilot:** Develop and implement cross-agency "coordinated care plans" for identified high users of care in Eastern region. **Initial Target Population:** MI √; ADA √ CY&F: ADULT √; OA √	SLRHC Behavioral Health Steering Team DMH OOT & Divisions of CPS/ADA	A E	4	Medium												
4.3	**Children's System High User Analysis:** The efficacy of services for children with SED will be assessed. Data will be collected to identify high users of services with poor outcomes. Service and system changes will be identified to improve outcomes for children. **Initial Target Population:** MI: ALL √ CY&F √	DMH OCCMH	A E	8	Medium												
4.2	**Early Childhood Initiative:** An interagency group will be convened to develop an early childhood consultation model as well as identifying the infrastructure for a service delivery system that is based on evidence based practices for the early childhood population. **Initial Target Population:** MI: ALL √ CY&F √	DMH OCCMH HeadStart MOHealthNet DHSS DSS DESE	E	9	Low												

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
4.2	**School-based Bullying Prevention:** • Identify community professionals for scholarships to attend certified training and learn to implement school-wide bullying prevention with fidelity. • Partner trainers with 3-4 schools each to begin program implementation by training a school based bullying prevention committee. Evaluation is built into the implementation process. Anticipated short term impact:: reduction in bullying; improvement in school climate including attendance, grades, and attitudes; reduction in vandalism and discipline referrals. **Initial Target Population:** MI: DD: ADA: ALL √ CY&F √: ADULT: OA: ALL	DMH, DHSS, MO Center for Safe Schools & Individual School Districts	E	2	Medium												>
4.2	**School Based Services Expansion:** • Implement FY08 Budget Item to fund school based mental health services in on Missouri School District. Build on FY08 initiative to begin expansion of school based mental health services state-wide. • FY09 budget request to expand School-based Mental Health Services by partnering with local school districts and community mental health centers utilizing matching funds and MO HealthNet (Medicaid) funding. • If budget item funded, implement in number of school districts allowed by funding. If budget item isn't funded, determine next steps. • Implement St. Joseph Circle of Hope Grant targeting integration of physical and behavioral health integration in school settings in 2 – 3 elementary schools. **Initial Target Population:** MI √: DD: ADA: ALL CY&F √: ADULT: OA: ALL √	DMH, DESE, Coalition of CMHCs, Individual School Districts	C E	9	Medium-High	<											>

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4.2	**Bright Futures Targeted Capacity Building:** Up to six communities will be selected to participate in the Missouri Bright Futures effort. Partners in the community will include the school districts, early care and education, Children's Division, Health Departments, Court/DJO and other child serving entities. Communities selected will participate in training and support in mapping the resources and needs of the community, organizing the resources of the community to address system needs, and individualizing resource allocations within the community to improve the outcomes for individual youth. **Initial Target Population:** MI:	DMH, DHSS, DSS, DESE, University of Missouri Center for the Advancement of Mental Health Practices in Schools, Head Start Collaboration, Missouri Student Success Network	C E	2	Medium												
	DD:																
	ADA:																
	ALL: √																
	CY&F: √																
	ADULT:																
	OA:																
	ALL:																
3.1 4.2 5.2 6.2	**Autism Treatment Services:** • Provide services to families and individuals impacted by autism spectrum disorders through the Missouri Parent Advisory Councils (PACs). • Contract with academic institutions known as Missouri Autism Centers for Excellence (MO-ACE) to develop and deliver best practices to individuals with autism spectrum disorders. • Partner with the MU Thompson Center to provide intensive behavioral supports to children and young people . • Establish Office of Autism within the DMRDD. • Review recommendations from Governor's Blue Ribbon Council to identify those that can be implemented. **Initial Target Population:** MI:	DMH Division of MRDD & PACs & MO-ACEs	C	9	Medium to High												>
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	CY&F																
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4.3	**Crisis Intervention:** Expand crisis intervention capacity through partnerships with local organization. **Initial Target Population:** MI: DD √; ADA; ALL CY&F; ADULT; OA; ALL √	DMH Division of MRDD	C	9	Medium												>
5.1	**Workforce Development Plan:** Review Annapolis Coalition Action Plan recommendations and current SAMHSA priorities for workforce development. Develop initial scope and steps for workforce development plan. **Initial Target Population:** MI; DD; ADA; ALL √ CY&F; ADULT; OA; ALL √	DMH OOT & OOCCMH	A E	9	Low												
5.1	**E-learning Platform and Core Safety Training Modules:** E-learning accounts for direct care staff will be established in all DMH facilities. Core training to be available on the web with safety as an important component. SB 3 requirements will be included in the safety modules being developed. FY 09 budget request submitted includes expansion to community providers, basic certification for direct care staff and supervisory training. **Initial Target Population:** MI; DD; ADA; ALL √ CY&F; ADULT; OA; ALL √	DMH	C E	2	Medium	<											>
5.1	**College of Direct Support:** • Pilot College of Direct Support, a web-based training for direct support professionals, with DD service providers. • Expand College of Direct Support to additional providers (included in DMH FY09 budget request). • Explore expansion of College of Direct Support to other segments of Missouri's long term care system. **Initial Target Population:** MI; DD √; ADA; ALL CY&F; ADULT; OA; ALL √	DMH Division of MRDD, MPC, & UMKC IHD MACDDS & MARF & MO-ANCOR	E	2	Medium	<											>

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5.1 5.2 5.3 5.4 6.1 6.2	**Evidence Based Practices Workgroup:** Convene cross-cutting workgroup to : • Begin with DMH system and determine level of EBP emphasis per division • Determine policy around what amount/level of evidence is needed to use public funds. • Address how to handle service to science advances. **Note: In** DMH CPS, EBP programs are progressing and feedback loop established. **Initial Target Population:** MI: √ / DD / ADA / ALL CY&F / ADULT / OA / ALL: √	TWG EBP Workgroup	A E	9	High												v
2.4 5.4 6.3	**Quality Service Review (QSR):** The quality service review is a tool that measures the quality of interactions between frontline practitioners and children and their families and the effectiveness of the services and supports provided. Plans for FY 08 and O9: • More families will be trained as reviewers; • Baseline data will be obtained from the 11 system of care sites and follow-up QSR will be conducted for mature sites. • Adult QSR adaptation will be developed. **Initial Target Population:** MI: √ / DD / ADA / ALL CY&F / ADULT / OA / ALL: √	DMH OCCMH & Division of CPS & CSMT	A E	4	Medium												v
5.1 2.4	**Trauma Informed Care** An organizational assessment of trauma care will be completed. Workforce development and training needs will be identified and prioritized. Technical assistance will be secured and training implemented and evaluated. **Initial Target Population:** MI / DD / ADA / ALL: √ CY&F / ADULT / OA / ALL: √	DMH OOT & OCCMH	E	2													

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
5.4	**Common State Identifier:** • The Departments of Social Services (DSS), Health and Senior Services (DHHS), and Mental Health (DMH) have adapted the Document Control Number (DCN) as the common identifier. • Complete assignment of DCNs to all DSS, DHHS, and DMH consumers who currently don't have one. • Continue discussions with the Departments of Corrections and Elementary and Secondary Education to adopt the common identifier or a common methodology to link consumers within their systems to those in the other human service agencies. **Initial Target Population:** MI / DD / ADA / ALL √ CY&F / ADULT / OA / ALL √	OOA & State Human Service Departments	A E	9	Medium	<											>
5.4	**Data Warehouse:** • Identify best solution to developing and housing interagency data warehouse containing data from all state human service agencies to provide more accurate and timely information concerning individuals served across the agencies. • Develop the interagency data warehouse. • Begin with a children's services data warehouse and then expand across the lifespan. **Initial Target Population:** MI / DD / ADA / ALL √ CY&F √ / ADULT / OA / ALL	OOA & State Human Service Departments	A E	5	High	<											>

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
5.4	**Electronic Records:** • MO FY09 proposed budget item provide bar coding and medication dispensing software and hardware to reduce medication errors within state-operated psychiatric inpatient facilities as the first step toward identifying and implementing an electronic medical record. • If budget item funded, implement. If not, determine next steps. • DMH partnership with MO HealthNet (Medicaid) to coordinate development of an electronic Medical Health Record. **Initial Target Population:** MI √ / DD / ADA / ALL CY&F / ADULT / OA / ALL √	DMH Division of CPS	A E	9	High												
6.1 6.2 6.3	**State-Local Infrastructure Development Plan:** • Establish subcommittee to review current state and local cross-departmental initiatives, statutory mandates and department regulations. • Establish preliminary criteria for formal partnership agreements with local bodies. • Engage local leaders in dialogue to determine state-local infrastructure development. Consider mini-policy academy format or summit. • Propose recommendations to full TWG and HSCC for enduring state and local infrastructure to continue transformation efforts beyond grant to include cross-departmental structure for consumer input. • **Initial Target Population:** MI / DD / ADA / ALL √ CY&F / ADULT / OA / ALL √	TWG	A	9	Medium												

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
6.1	**Older Adult Workgroup:** • Charter workgroup to identify the components to be included in an operational plan for older adults that articulates the components of the Mental Health Transformation Plan. This plan will aim toward the development of a system of care for older adults. • Secure consultant contract with national expertise in mental health and aging issues and identify to provide technical assistance to workgroup. • Propose the management structure for ongoing monitoring and oversight of the operational plan. • Identify key stakeholders to propose the next steps in implementing the system of care plan in local communities. • Implement the plan embodying a comprehensive and coordinated system of care for older adults in selected local communities. • Explore the proper use of mental health services and supports for persons with Alzheimer's disease and related dementias, as well as those persons with Alzheimer's type disease and co-occurring mental illnesses. **Initial Target Population:** **MI** / **DD** / **ADA** / **ALL** √ **CY&F** / **ADULT** / **OA** √ / **ALL**	**TWG**	**C**	**9**	**Medium to High**												>
6.2	**Regional Collaboratives:** Develop partnerships and incentives to implement regional collaboratives that integrate metal health with overall local community health planning and initiatives. Based on initial successful partnership with SL Regional Health Commission in Eastern region, develop principles and criteria to expand collaboratives that can be adapted to fit local needs in other areas of state and achieve broader transformation goals. Initiate partnership agreements with 2 additional regional areas. Work with local private foundations to support and leverage change efforts. **Initial Target Population:** **MI** / **DD** / **ADA** / **ALL** √ **CY&F** / **ADULT** / **OA** / **ALL** √	**DMH OOT TWG**	**C**	**9**	**High**												

Goal/Objectives	2008 Priority Actions	Lead Agency/Group and partners	ACE Goal	Primary GPRA	Level of Complexity	January	February	March	April	May	June	July	August	September	October	November	December
6.1	**Transitional Youth:** Develop plan to establish workgroup or committee within current management team/workgroup structure to begin development of system of care to meet needs of transitional youth. Recommend structure to TWG. **Initial Target Population:** MI: DD: ADA: ALL √ CY&F: ADULT: OA: ALL √	DMH OOT & OCCMH			Low												
6.3	**Community of Hope Pilots:** Develop criteria and proposal to provide seed funding to local communities to begin process of community assessment and capacity building. Identify state and local partners and linkages with public education actions. Provide recommendations to TWG for implementation. **Initial Target Population:** MI: DD: ADA: ALL √ CY&F: ADULT: OA: ALL √	DMH OOT & OCCMH	C	9	Low												
6.1	**Emerging Issues:** • Traditionally it is difficult for state entities to respond rapidly to issues that emerge. If an appropriate issue emerges, identify staff for responsibility. • Research for outcomes and appropriateness. • Develop a potential plan for implementation. • Present to TWG. **Initial Target Population:** MI: DD: ADA: ALL √ CY&F: ADULT: OA: ALL √	TWG, DMH and others depending on identified issue	A C E	9	Medium												>

Part 4: Governance

Overview

The Governor established two principle bodies to lead Missouri's mental health system transformation: the **Human Services Cabinet Council (HSCC)** and the **Transformation Working Group (TWG)** (Appendix A). Both have a primary membership of the senior leaders from designated state departments. The TWG Co-Chairs and principle staff are based in the Director's Office of the Department of Mental Health (DMH) to lead and staff the planning process in partnership with other state mental health services agencies. This includes leadership and staffing from the DMH Office of Comprehensive Child Mental Health.

In addition, workgroups, management teams and committees are chartered by the TWG as appropriate to develop and implement the plan. The following groups are incorporated into the structure as well: **Comprehensive State Management Team (CSMT)** and the **Stakeholder Advisory Group (SAG**) for children; the CPS **State Advisory Council** links the Block Grant planning requirements as required by SAMHSA; and the **MRDD Transformation Steering Committee**.

The TWG coordinates efforts with other state and local governing and advisory bodies that address issues relevant to mental health. At the state level, coordination occurs with groups such as the Governor's Strategic Prevention Advisory Committee and Early Childhood Coordinating Board among others. At the local level, coordination occurs with existing regional collaboratives, local system of care teams and other community boards and groups. The community focus of this plan will require a greater degree of collaboration between the state and local level as this plan is implemented. Table 16 on the following page provides a visual outline of the governance structure and its relationship with other bodies. A description of the purpose and roles of each group is provided as well.

Human Services Cabinet Council (HSCC)

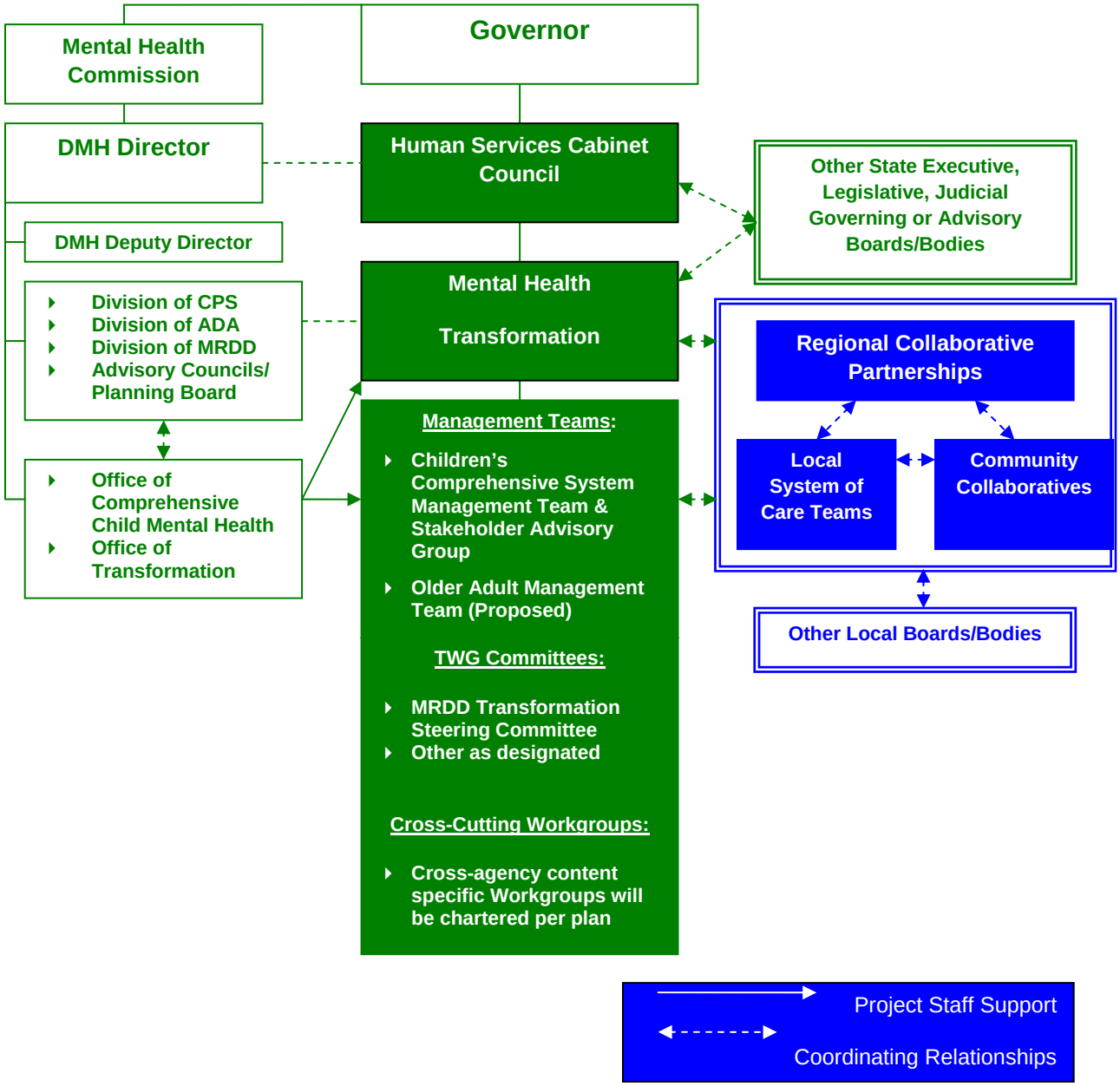
A Cabinet subgroup serves as the governing body of the Transformation Working Group and steers the mental health transformation process. The HSCC is chaired by the Governor's Chief of Staff. Members include the Directors of the Departments of Mental Health (DMH), Social Services (DSS), Health and Senior Services (DHSS), Elementary and Secondary Education (DESE), Corrections (DOC) and Public Safety (DPS). The principle role of the HSCC is to:

- Establish the strategic direction of the process across departments;
- Facilitate alignment and coordination with other Governor and departmental priorities, and with other branches of government; and
- Serve as the final approval body of the Comprehensive State Mental Health Plan.

Transformation Working Group (TWG)

The TWG is a Governor-appointed board established through Executive Orders 06-39 and 07-15. Members include key Governor's Office and departmental senior leaders, consumer and family experts, and other public leaders. The chairpersons and principle staff are based in the DMH Director's Office to lead the planning process in partnership with other mental health services agencies. The principle responsibility of the TWG is to 1) create a Comprehensive Mental Health Plan for Missouri that transcends state department boundaries and fully integrates the current Comprehensive Children's Mental Health Plan and 2) lead the implementation of the plan once developed. In order to achieve this task, the roles of the TWG will evolve across the course of this process to include:

TABLE 16:
Missouri Mental Health Transformation Governance Structure



Transformation Working Group (TWG) (con.)

- Coordinate and/or integrate the activities of the TWG with other Governor, state department, legislative and judiciary initiatives;
- Initiate dialogue, seek input and engages stakeholders;
- Serve as the chartering authority for specific workgroups and deploy staff, as appropriate, to work on key TWG committees;
- Propose and recommend changes to the current mental health system, develop priorities and coordinate implementation;
- Build support for the changes proposed through communication, education and organizational support and commitment;
- Mobilize and coordinate resources for achieving the plan; and
- Ensure evaluation of efforts and promote sustainability.

Children's Comprehensive System Management Team (CSMT)

Senate Bill 1003 mandated that DMH, in partnership with all child-serving departments, develop a unified, comprehensive children's mental health system. This legislation required a Comprehensive System Management Team responsible for developing and implementing a comprehensive mental health plan for children. An initial goal of the current children's comprehensive plan is "to create a formalized structure for policy and decision-making across departments at the cabinet level." Missouri's Mental Health Transformation Initiative provides that structure and moves the responsibility for system wide mental health plan and policy development to the TWG and HSCC. The CSMT now receives principle policy direction from the TWG yet remains responsible for implementing the children's components of the comprehensive plan. The CMST receives principle leadership and staff support from the DMH Office of Comprehensive Child Mental Health. The roles of the CSMT include:

- Develop and implement cross-departmental work plans for identified goals and strategies;
- Assist in the development of local system of care infrastructures and provide technical assistance and policy direction to local system of care policy teams;
- Coordinate activities across departments at the state and local levels;
- Build support for the changes proposed through communication, education and organizational support and commitment.

Children's Stakeholder Advisory Group (SAG)

SB 1003 also required DMH to establish a stakeholder advisory committee to provide input to the CSMT and to assist in developing strategies to ensure positive outcomes for children. The SAG membership requires a majority of family and youth representation. By incorporating children's policy and planning to the TWG, the SAG serves a principle advisory role to both the TWG and CSMT. The SAG roles include:

- Provide constructive input and feedback to the CSMT and TWG regarding Transformation activities relating to children and families;
- Provide direct input to initial ideas and draft plans of the workgroups and TWG;
- Provide recommendations for final plan approval prior to submission to HSCC; and
- Disseminating information to key children's system stakeholders in the broader community.

CPS State Advisory Council (SAC)

The State Advisory Council (SAC) is comprised of 25 members who advise the DMH Division of Comprehensive Psychiatric Services and make recommendations to improve the system of care in mental health. Council membership is required by federal law to have a majority of mental health consumers, including parents of children receiving services and family members. As SAMHSA mental health block grant planning is required to be explicitly linked to this plan, the SAC serves a principle advisory role to the TWG plus the SAC chair serves on the TWG. The Council roles include:

- Provide constructive input and feedback to the TWG regarding Transformation activities;
- Provide direct input to initial ideas and draft plans of the workgroups and TWG;
- Align mental health block grant planning with Comprehensive State Plan
- Disseminate information to key system stakeholders; Establish input process for adult and older adult stakeholder groups and DMH cross-divisional advisory bodies.
- Host regional town hall meetings and other local input opportunities.
- Provide recommendations for final plan approval prior to submission to HSCC.

MRDD Transformation Steering Committee

The MRDD Transformation Steering Committee was established upon award of a five- year transformation grant from the Center for Medicaid and Medicare Services (CMS) specific to the MRDD population. The grant application was submitted by the Division of MRDD at the same time the application for the SAMHSA Transformation grant was submitted. Both applications proposed the same governance structure. As the CMS grant was awarded prior to the establishment of the HSCC and TWG, a steering committee was established to guide the initial plan development. Once the SAMHSA grant award was made and the TWG appointed, this steering committee was incorporated into the overall governance structure. The MRDD Steering Committee guides the implementation of strategies and actions in this plan that are specific to persons with developmental disabilities.

Chartered Workgroups, Management Teams and Committees

Given the complex analysis and planning required to develop and implement a comprehensive plan, the TWG will charter workgroups, cross-departmental management teams and committees as appropriate. The TWG initially chartered workgroups (Appendix B) around the six goals of the New Freedom Commission report. Each workgroup was responsible for conducting the primary analyses and creating recommended goals/strategies specific to their focus area. Workgroup membership included representation from relevant state departments and other public offices, consumer and family members, provider and advocacy organizations and other stakeholders with special expertise or interest. Workgroup efforts were coordinated across workgroups and with other relevant taskforces and committees. As the TWG moves to the phase of plan implementation, workgroups and committees will be established where needed to guide and implement priority actions.

Linkage with other State Bodies

The complexity of the system requires a major effort to coordinate activities with other state-level bodies whose role is critical to successful plan development and implementation. Particularly, the General Assembly receives updates on the planning process and works with the Governor, the DMH Director

and the other Cabinet Council members to establish legislative and budget priorities and actions. Also, the Missouri Mental Health Commission, a seven-member body appointed by the Governor to provide policy advice and direction to the DMH Director, receives regular updates from the TWG and advises the department on policy priorities. In addition to the these bodies, the TWG strives to coordinate its work with other groups including the Governor's Strategic Prevention Advisory Committee, the Early Childhood Coordinating Board, and the Chief Justice Initiative on Mental Health among many others.

Collaboration with Local Groups

An array of local planning groups and formal boards exist throughout the state. The emphasis placed in this plan to create shared state-local and public-private ownership and investment requires coordination with exiting and emerging local efforts to successfully meet the goals of this plan. Currently, the Comprehensive System Management Team assists in the development of local system of care teams and provides technical assistance and policy direction to these teams. Recently, the TWG partnered with the St. Louis Regional Health Commission to link local mental health transformation activities with the state initiative. The development of local capacity and the state-wide expansion of these structures are key strategies contained within this plan. Numerous other bodies exist that are linked with various state efforts such as the regional support centers established as a result of Missouri's suicide prevention plan. The TWG is committed to developing effective partnerships with local groups to achieve the goals this plan.

Sustainability

The TWG recognizes the inherent barriers to change and has attempted to identify and maximize the key levers of change throughout the initial planning process.

- To address the conversion of an entire system takes buy-in from consumers, providers, employees, educators, citizens, policy makers and others from across the system. **Every attempt was made to be inclusive and transparent throughout the planning process.** The planning process encompassed the viewpoints of a large and diverse constituency. The TWG sought input from all sides of the mental health system so they recruited leaders and experts from all sectors to provide their views and concerns in shaping this effort. All workgroup meetings were open to the public and proceedings posted to the website.
- **A logic model** (Appendix E) **was developed** to serve as a broad outline and guide to the planning process. In the model, various inputs (resources, technical assistance, and levers of change) were identified along with actions that influence and support the desired objectives and strategic goals.
- All **workgroup meetings were facilitated by skilled and objective facilitators** through the Change and Innovation Agency using a variety of methods to ensure that the various aspects of the system were addressed, common themes and potential overlap across workgroups identified and discussed, and diverse perspectives incorporated.
- A consultant with expertise in "systems modeling" assisted the workgroups during their initial meetings with **a group model building (causal mapping) process** based on principles of system dynamics. This model was then integrated across groups and updated as objectives, strategies and actions were identified during the planning process. The model was used to help the TWG and workgroup participants see the larger whole, identify potential leverage points for change, identify potential threats to the implementation and sustainability of recommendations and prioritize actions. Appendix C provides a summary of the causal mapping and qualitative model developed in 2007 as part of the planning process.

Part 4: Governance

The TWG is committed to the sustainability of this initiative far beyond the time frame of the SAMHSA grant that is currently supporting it. The group will continue to employ the strategies listed above as it moves into plan implementation. Also, many objectives and core strategies are directly linked with sustainability. These include, but are not limited to, the establishment of a permanent mental health foundation to support public education and consumer participation at the state level, policy and financing changes to support and sustain changes in practice and the establishment of an enduring infrastructure for state and local planning beyond the life of the transformation initiative. Additionally, the TWG has incorporated the development of a sustainable "business plan" as a key action step into some priority actions (e.g. Mental Health First Aid Training.) Much work remains and the fate of this plan will certainly be influenced by a complicated set of political and economic forces. However, the shared vision and practical blueprint outlined in this plan will be used to guide collective action needed to create sustainable Communities of Hope through the state.

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Appendices

Appendix A

Mental Health
Transformation Working Group
Membership Listing

Diane McFarland Chair DMH Office of Director	Benton Goon Co-Chair DMH Office of Director
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Open Consumer Leader	John Heskett Director, Office of Comprehensive Child Mental Health
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Jeanne Loyd Asst Commissioner DESE Division of Vocational Rehab	Heidi Atkins Lieberman Asst. Commissioner DESE Division of Special Education
Open Missouri Housing Commission	Open-Pending Office of State Court Administrators

Appendix B

Consumer and Family Workgroup **Membership Roster**	
Co-Chair Leigh Gibson Director Office of Consumer Safety Department of Mental Health Jefferson City	Co-Chair George Boyle MO Planning Council for Developmental Disabilities Columbia
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Disparities Are Eliminated Workgroup
Membership Roster

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Appendix B

Easy, Early Access Workgroup
Membership Roster

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Appendix C Causal Mapping*

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Introduction

Transformation in Missouri involves changing a system that is inherently complex, dynamic, and spanning multiple sectors of care. Seeing the whole is challenging as each stakeholder sees only a facet of the overall system. Methods that can help people visualize the interconnections between different sectors of care can aid in the planning and evaluation of transformation efforts.

System dynamics (Levin & Roberts, 1976; Sterman, 2000) is one way to understand systems and how they change. The goal of system dynamics is to improve the mental models that stakeholders use to understand and change a system. This can happen through qualitative system dynamics modeling using techniques such group model building (Andersen & Richardson, 1997; Vennix, 1996, 1999), or more formally by developing quantitative models that can be studied through computer simulations and empirical research.

System dynamics approaches understanding systems and change by focusing on the role of reinforcing and balancing feedback loops in a system, identifying stocks and flows, and recognizing the importance of delays on system behavior. Feedback loops are causal chains where the consequences of actions "feed back" to influence the causes. Reinforcing feedback loops accelerate change. Balancing loops slow down or counteract the direction of change.

Also important to system dynamics is the distinction between stocks and flows. Stocks represent the states of a system; for example, the number of people waiting for services or the number of people not seeking but needing services. Flows represent transitions between the stocks; for example, referring people to services or people dropping out of services.

Lastly, delays play an important role in understanding system behavior. Delays make it difficult to see the long term effects of actions. Delays can involve the time it takes for people to access appropriate services, but also the time it takes to accurately perceive the outcomes of actions. Evaluation of services, for example, involves delays as the full benefits of treatment or support might not be known for many years.

System dynamics was used to support the Missouri Mental Health Transformation project. This appendix provides summary of the causal mapping and qualitative model developed in 2007 as part of the planning process. The qualitative system dynamics model represents a collective view of mental health transformation in Missouri, which includes services and supports for persons with mental illness, addictions, and developmental disabilities. The purpose of the Mental Health Transformation (MHT) model was to help participants see the larger whole, identify potential leverage points for change, and identify potential threats to the implementation and sustainability of recommendations.

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The model was based on an exercise conducted during the initial workgroup planning meetings, subsequent input from the core working group, the leadership meeting in July 2007. Over 240 people participated in the model building process, including consumers and family members, providers, administrators, academics, and policy makers.

The Mental Health Transformation (MHT) model contains nearly 300 variables with 38 stock variables and tens of thousands of feedback loops. While obviously complex, it still represents a significant simplification of reality. This appendix provides an overview of the basic population model, description of the main reinforcing and balancing feedback loops discussed during the planning process, and analysis of the potential short-term and long-term threats to implementation and sustainability of transformation initiatives. The overriding theme from this analysis is the need to focus on eliminating barriers to accessing appropriate care and support and building system capacity for increasing sustainability of transformation efforts.

Population Model

The basic population model of transformation is shown in Figure 1. It represents the state of all persons within a given community, including those that are well, those that need services, and those that are receiving some type of services or support. Boxes represent the stocks or the number of people in various states. For example, the box labeled "Personal Wellbeing" represents the number of people in a community who are well, living independently, and achieved resiliency. The double lines with arrows represent flows or transitions of people between the stocks. How many or how fast people transition from one stock to another stock is regulated by a rate variable depicted as a symbol of a valve. People can begin in any state, transition at different rates over their lifespan, and cycle in and out of services and supports. The sum of all the people in the stocks represents the total or base population for a community.

It is important to note that system dynamics adopts a continuous perspective as opposed to a discrete perspective of change. This means that instead of viewing people as either in one stock or another stock where people "jump" from one stock to another, people can be partly in one stock and partly in another stock, and transitioning from one stock to another is a gradual and continuous process. For example, a person might still be receiving some appropriate services and supports while also having some independence and experiencing personal wellbeing.

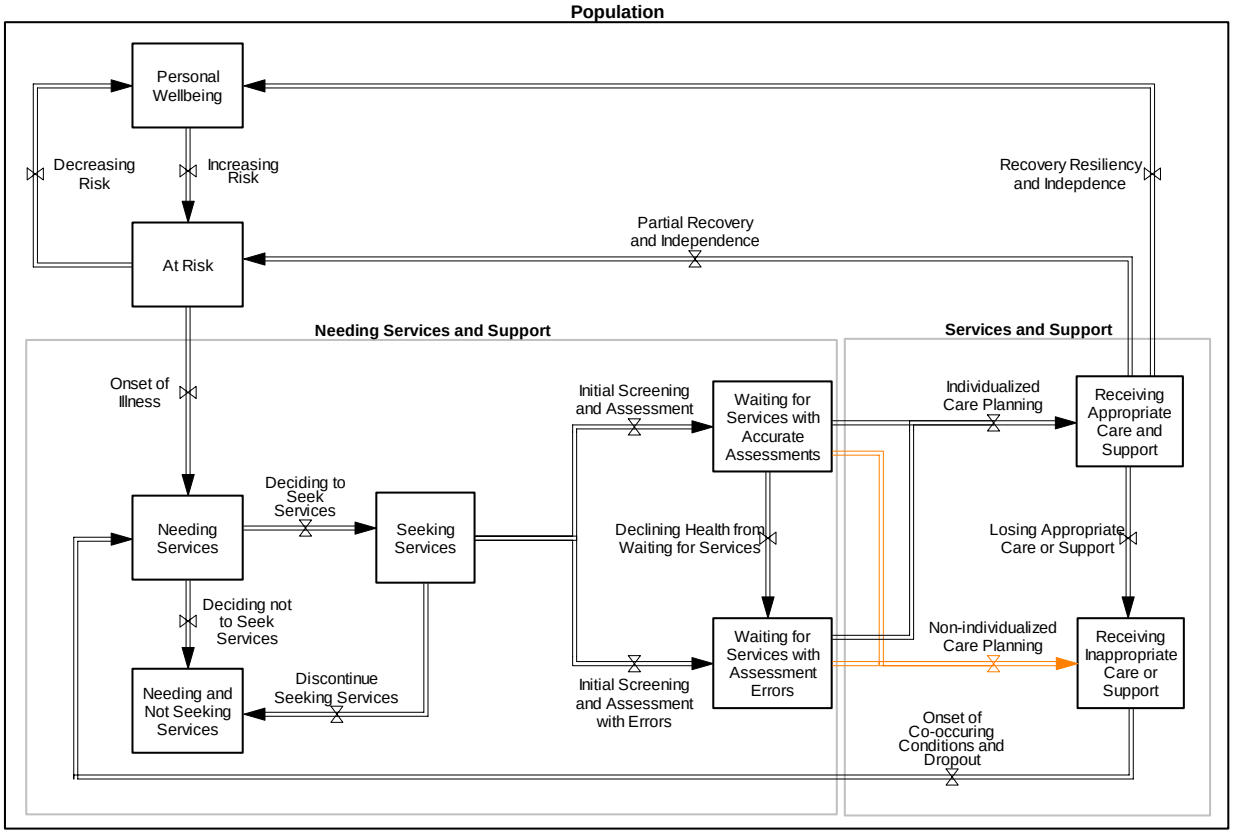
Main Stock Variables

In the population model, people can be in any of nine states. People in a state of *Personal Well Being* are fully functioning, not receiving or needing services, resilient, living independently, and not at risk. People are *At Risk* when they are fully functioning, living independently, and at risk for conditions that would need services or supports. People are *Needing Services* when they have a condition that has not been screened and assessed and could benefit from services or supports, but are not yet seeking services and receiving appropriate care and support. People are *Seeking Services* when they decide to access services or supports in response to needs. People can also be *Needing and Not Seeking Services*, either because they decide not to seek them in the first place or because they discontinue seeking services and supports.

People enter the service system through screening and assessments. The service system is represented by the light gray box in Figure 1. No screening and assessment procedure is error free, and all screening and assessment tools generate contribute to persons with incorrect assessments. Thus people who have been screened or assessed for mental illness, substance abuse, or development disabilities are either *Waiting for Services with Accurate Assessments* or *Waiting for Services with Assessment Errors*.

In transformation, one is concerned with not just the delivery traditional services, but also supports from community, employers, neighbors, families and friends. Both services and support need to be appropriately matched to individual needs. When this happens, people are in the stock of *Receiving Appropriate Care and Support*. Services can be inappropriate if either the care or support is inappropriate. For example, one might being receiving appropriate counseling, but inappropriate support because one cannot access needed ancillary services. Similarly, housing supports could be excellent, but one is unable to access culturally appropriate evidence-based practices. Both would place the person in the stock or state of *Receiving Inappropriate Care or Support*.

Figure 1 Population Model



Main Flow or Transition Variables

There are fifteen flows or transitions between these nine stocks. People who in a state of are in a state of *Personal Wellbeing* move to *At Risk* with *Increasing Risk* of mental illness, substance abuse, or developmental disability. For example, someone experiencing a job transition might be at risk for an adjustment disorder. Similarly, people can move from being *At Risk* to *Personal Wellbeing* with *Decreasing Risk*. This might happen with the aid of natural supports or more formally through primary prevention services. Some people *At Risk* will move to *Needing Services* with the *Onset of Illness* such as substance abuse, mental illness, or disability. Some people *Needing Services* will *Decide to Seek Services* and be actively *Seeking Services*. Of these, some will decide to *Discontinue Seeking Services* and transition to *Needing and Not Seeking Services*. For example, they might not be able to access information about available

services in their community or they may encounter stigma from their employer about mental illness, substance abuse, or developmental disability and decide not to seek services despite having needs. There are also others who do not seek services in the first place, although this might not be a decision; for example, a person with depression who does not know that effective treatments are available would move people from *Needing Services* to *Needing and Not Seeking Services* via *Deciding not to Seek Services*. It is important to note that in this version of a generic population structure, there are no outflows out of *needing and Not Seeking Services*. This places the emphasis on identifying existing mechanisms or developing new interventions that move people from this stock into the services.

Some people *Seeking Services* will transition into the service system through initial screening and assessments. Since not all screenings and assessments are accurate, some transition to waiting for services via *Initial Screen and Assessments* while others transition to waiting for services through *Initial Screen and Assessments with Errors*. Moreover, the longer people wait for services, the more likely their condition has changed from the initial screening and assessment. This does not affect those who are already *Waiting for Services with Assessment Errors*, but it does have implications for those *Waiting for Services with Accurate Assessments*. The longer the wait for services, the more likely people are to have assessments that are out-of-date and inaccurate. This transition is represented by the rate *Declining Health from Waiting for Services*.

People move from waiting for services to receiving care through referral, intake, and care planning. *Individualized Care Planning* will match appropriate services to individual needs, regardless of whether the initial screening and assessment was accurate. This is represented by the flow *Individualized Care Planning* from *Waiting for Services with Accurate Assessments* and *Waiting for Services with Assessment Errors*. Similarly, non-individualized care planning can lead to care or support that is inappropriate even if one has an accurate screening and assessment. Hence, there is a flow *Non-individualized Care Planning* from *Waiting for Services with Accurate Assessment* and *Waiting for Services with Assessment Errors* to *Receiving Inappropriate Care or Support.*

People can also move from *Receiving Appropriate Care* to *Receiving Inappropriate Care*, which might happen with the limited availability of appropriate programs and services, the loss of other factors related to maintaining quality of care, or a change in clients' conditions leading to inappropriate care. This is represented by the flow *Losing Appropriate Care*. When someone is *Receiving Inappropriate Care* they may develop new needs or decide to discontinue ineffective services. When this happens, people leave the service system with unmet needs and return to the state of *Needing Services*. The transition is represented by *Onset of Co-occurring Conditions and Dropout*. This flow really represents two different types of transitions, the onset of co-occurring conditions and the discontinuation of ineffective treatment. Since receiving inappropriate treatment or supports has an opportunity cost of increasing the risk of conditions worsening and the development of co-occurring conditions, the two types of have been simplified into one flow.

Recovery and gaining independence is represented in Figure 1 as both an outcome and process. As an outcome, recovery and independence are represented as a transition from *Receiving Appropriate Care* to no longer needing services and entering either 1) *Personal Wellbeing* via *Recovery, Resiliency, and Independence*, or 2) *At Risk* via *Recovery and Independence*. The main difference between the two is whether an individual develops resiliency in addition to recovery and independence. Since persons who do not develop resiliency are still at risk, they return to the *At Risk* stock after discontinuing with services.

As a process, recovery and gaining independence are represented as the movement or paths through various states toward the states of being *Personal Well* or *At Risk*. These paths can be of any length, include cycles, and often specific to the individual. There are an infinite number of possible paths of recovery and gaining independence. For example, one person might cycle between *Personal Wellbeing* and *At Risk* and occasionally need services and receive some type of services and return to *Personal Welling* and *At Risk*, while another person's recovery and gaining independence might involve moving from *Needing Services* to *Receiving Appropriate Care*.

Feedback Loops

Central to all transformation initiatives is developing local community support for changes at the local level, which depends on two key variables in the model: public awareness and stigma. The analysis that follows begins with considering the potential feedback loops driving public awareness and stigma. Potential feedback loops are identified by looking at the delays or length of the feedback loops. Feedback loops with fewer links and shorter delays respond faster to change and have a larger effect over the short term.

Two influential stocks that have drive perceptions in the model are people *Receiving Appropriate Care and Support* and *People Needing and Not Seeking Services*. The three main rates affecting people receiving appropriate care and support are: 1) referrals through *Individualized Care Planning*, 2) *Recovery, Resiliency, and Independence,* and 3) *Losing Appropriate Care and Support*. Of these, addressing factors that lead to *Losing Appropriate Care or Support* is probably the fastest to respond to change.

The stock of people *Needing and Not Seeking Services* is influenced by 1) people *Deciding to Not Seek Services* in the first place, and 2) people *Discontinuing to Seek Services*. Increasing the number of people who decide to seek services will lead to an increase in the number of people waiting for services and the number of people deciding to discontinue seeking services. To avoid this, one needs to first slow the rate that people decide to discontinue seeking services.

Main Reinforcing Loops

The five main feedback loops are shown in Figures 2 to 4. Each feedback loop is shown in relationship to the basic population model from Figure 1. Plus signs indicate influence of one variable on the other in the same direction with everything else being equal, while minus signs indicate the influence of one variable on another variable in the opposite direction. The half circles with labels (e.g., R1, R2) designate feedback loops with the 'R' prefix indicating reinforcing feedback loops.

Peer to Peer Services (R1). More *Peer to Peer Services* means that *Populations Losing Appropriate Services* will slow down or decrease, reducing disparities and increasing the number of people *Receiving Appropriate Care and Support*. This can improve *Outcomes According to Families and Consumers,* improve *Quality of Life,* increase *Consumer Empowerment* and the number of *Consumers and Families in Leadership,* which feeds back to increase *Peer to Peer Services* forming the reinforcing loop R1 in Figure 2.

Figure 2 Peer to Peer Services (R1) and Consumer Empowerment (R2)

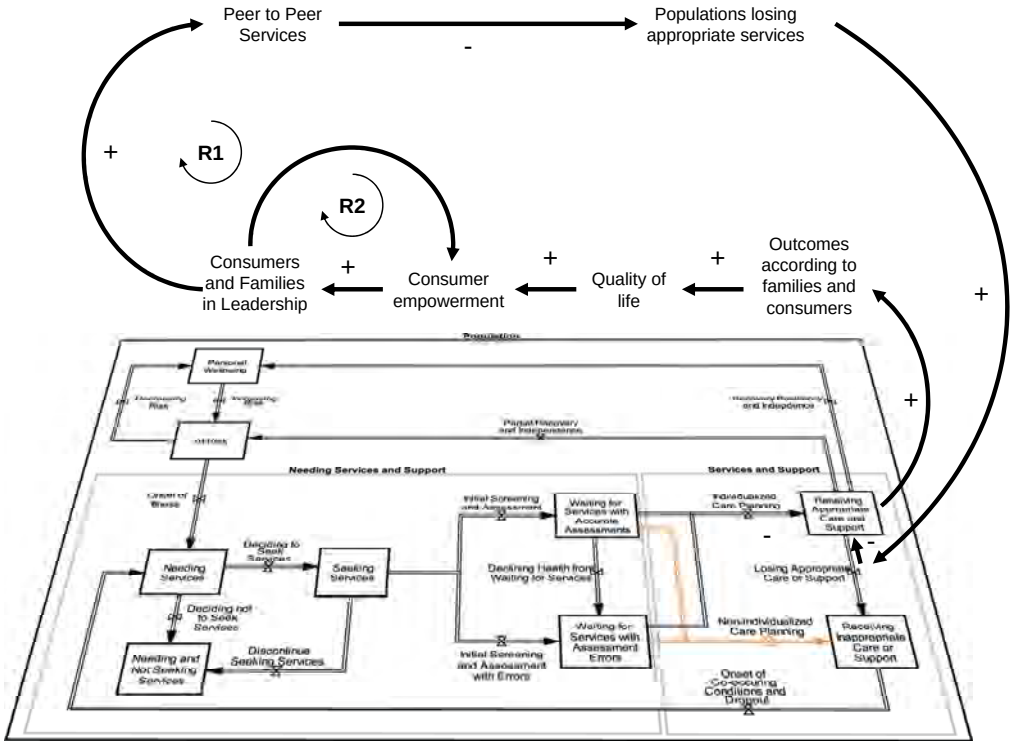
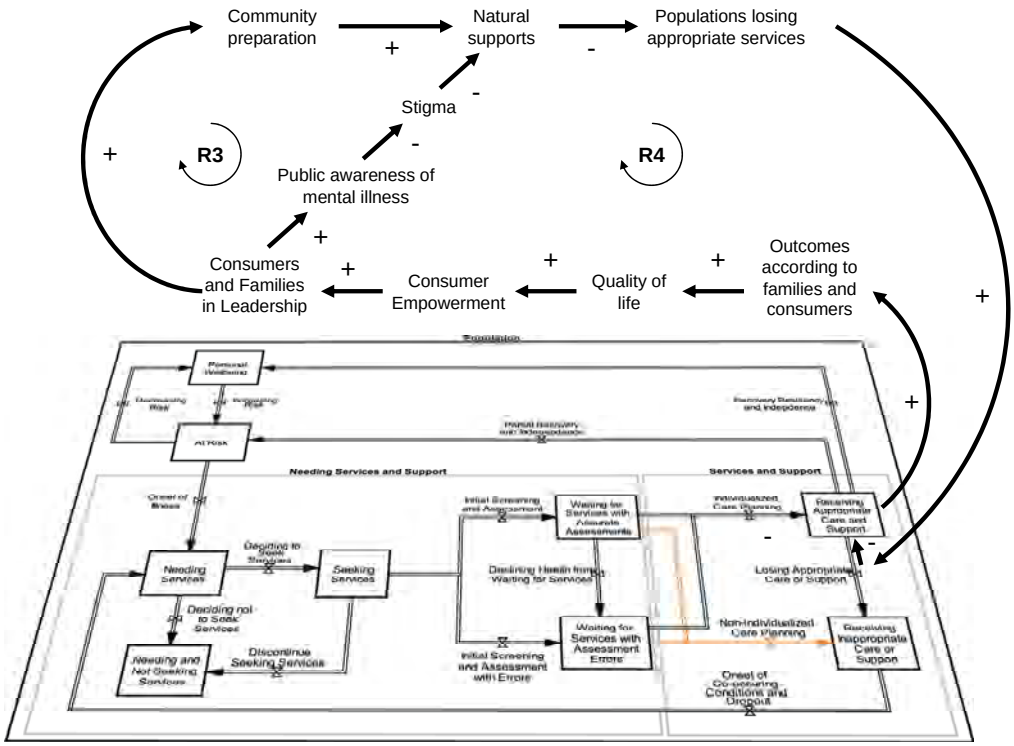


Figure 3 Community Preparation (R3) and Stigma (R4)



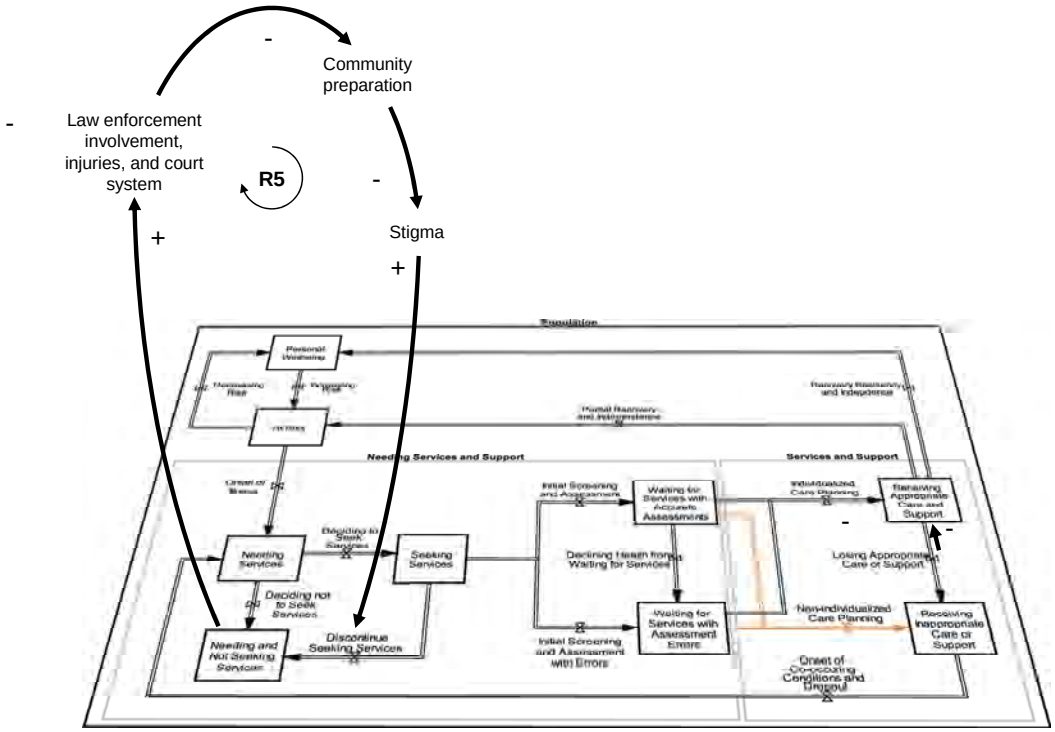
Consumer Empowerment (R2). Consumer Empowerment increases with more *Consumers and Families in Leadership*. This leads to more opportunities and empowerment, forming the reinforcing loop R2 in Figure 2.

Community Preparation (R3). Community preparation involves working with communities to support changes that increase natural supports and local investment in services and supports. Increasing natural supports helps prevent populations from losing appropriate services and slows the rate that people lose appropriate care and support. This leads to an improvement in outcomes, quality of life, and consumers and families in leadership. The results feed back to further prepare communities, creating the reinforcing feedback mechanism R3 in Figure 2.

Stigma (R4). Lowering stigma increases natural supports, which helps prevent populations from losing appropriate services and reduces the number of people who lose appropriate care or support. This increases outcomes and quality of life, which increases consumer empowerment, consumers and families in leadership, and public awareness. This leads to a further reduction in stigma and creates the reinforcing feedback mechanism R4 in Figure 3.

Law Enforcement Involvement (R5). The greater the involvement of law enforcement, injuries, and court system handling, the less compassionate the public is toward persons with mental illness, addictions, or developmental disabilities. Hence, efforts to reducing law enforcement involvement, injuries, and court system handling provide an opportunity for public awareness of to increase, which lowers stigma, and slows the rate that people decide to discontinue seeking services. This begins to lower the number of people needing and not seeking services and creates the reinforcing feedback mechanism R5 in Figure 4.

Figure 4 Law Enforcement Involvement (R5)



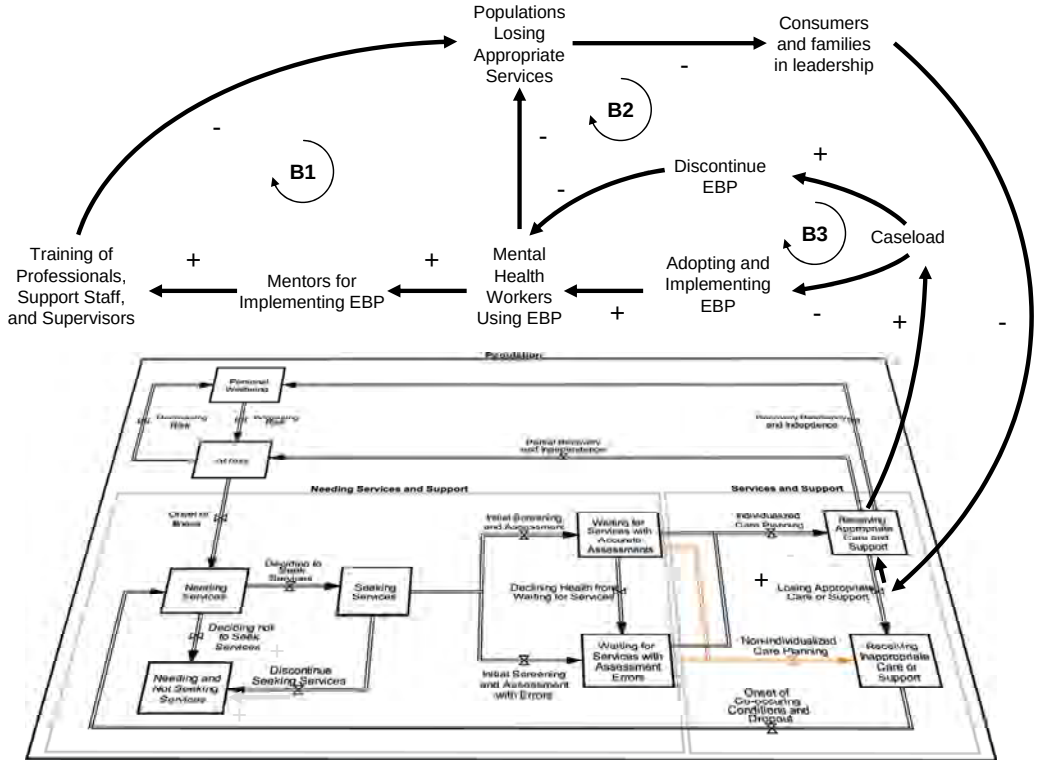
These five reinforcing feedback mechanism represent the most immediate drivers of people losing appropriate care or support and discontinuing to seek services in the model. There is considerable overlap between feedback loops. Thus efforts to influence one loop are likely to also affect other loops as well. The strength of these loops and whether they lead to overall improvements will depend on a variety of factors, including the length of the delays and influence of balancing loops that limit transformation.

Main Balancing Loops

Balancing loops in the model represent limits that can threaten the long-term sustainability of transformation efforts. Figure 5 through 7 depict some of the main balancing loops identified in the model. Balancing loops are labeled with a 'B' prefix. These feedback loops counteract the direction of change or slow the rate of change. Thus an increase in any variable from some intervention will be resisted by the balancing feedback loops.

Shortage of Mentors (B1). Slowing or decreasing the number of *Mental Health Workers using EBP* introduces additional constraints. Specifically, it limits the number of *Mentors for Implementing EBP*, which constrains *Training of Professionals, Support Staff, and Supervisors*. This lowers *Fidelity* of implementation and feeds back to lower the number of persons *Receiving Appropriate Care and Support*. This forms the balancing feedback loop reflecting the shortage of mentors B1 in Figure 5.

Figure 5 Shortage of Mentors (B1), Losing Fidelity (B2), and Slowing Adoption and Implementation of EBP (B3)

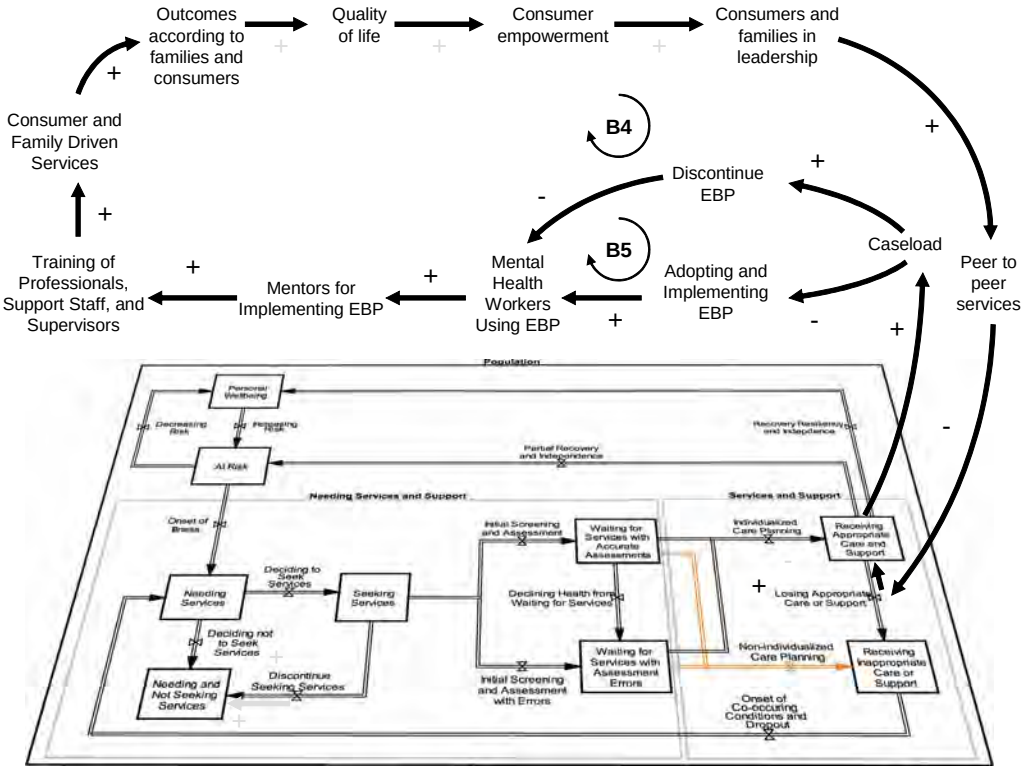


Losing of Fidelity (B2). Increasing *Caseload* also increases the rate that providers *Discontinue EBP*, which increases the rate that people are *Losing Appropriate Care and Support*, which lowers the number of people *Receiving Appropriate Care and Support*, forming balancing feedback loop B2 in Figure 5.

Slowing Adoption and Implementation of EBP (B3). The most immediate effect of increasing persons *Receiving Appropriate Care and Support* is on increasing *Caseload*. Increasing *Caseload* slows the rate that workers are *Adopting and Implementing EBP*, which lowers the number of *Mental Health Workers Using EBP* relative to where it would have been. This slows the increase in *Individualized Care Planning* and slows the growth of persons *Receiving Appropriate Care and Support*. This forms the balancing feedback loop B1 in Figure 5.

Limiting Peer to Peer Services (B4, B5). Increasing the number of people *Receiving Appropriate Care and Support* increases *Caseloads*, which can slow the rate of *Adopting and Implementing EBP* as well as increase the rate of *Discontinuing EBP*, which limits the number of *Mental Health Workers Using EBP*, *Mentors for Implementing EBP*, and *Training of Professionals, Support Staff, and Supervisors.* This limits *Consumer and Family Driven Services*, which limits improvements in *Outcomes According to Families and Consumers*. This could limit the involvement of *Consumers and Family Members in Leadership*, limit improvements in *Peer to Peer Services*, and increase the rate that people are *Losing Appropriate Care or Support.* This could lower the number of people receiving *Appropriate Care and Support*, forming two feedback loops, B4 and B5, as shown in Figure 6.

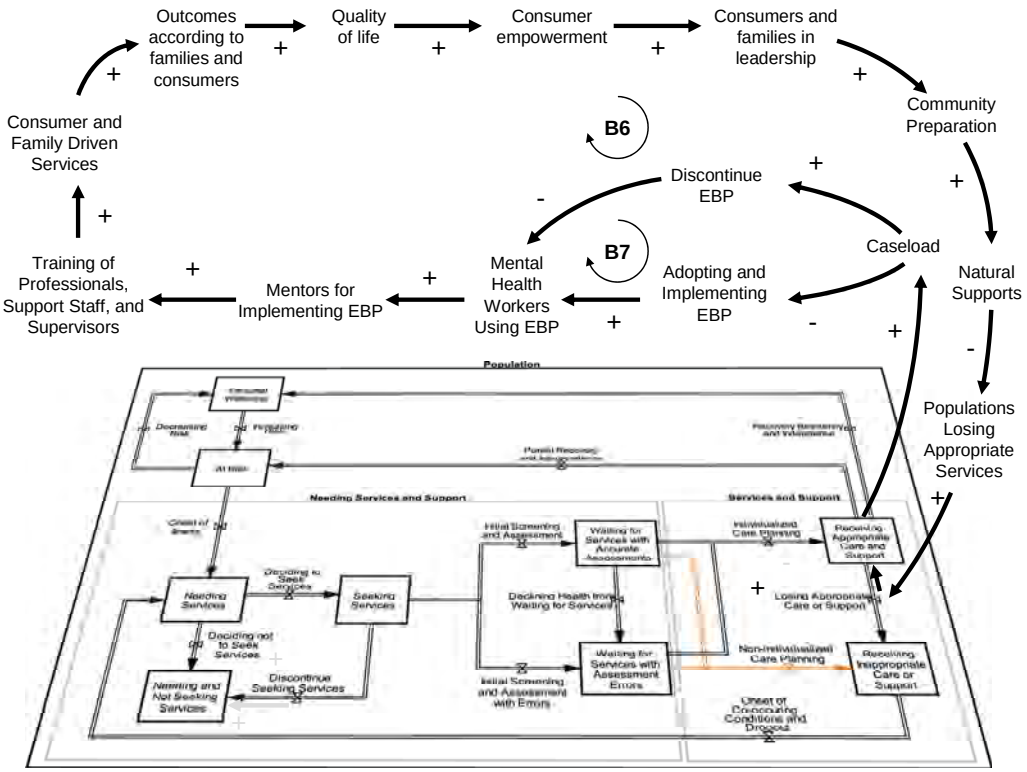
Figure 6 Limiting Peer to Peer Services (B4, B5)



It is important to note here that the model treats training of professionals, support staff and supervisors as separate from leadership or peer to peer service training. In particular, training of consumers and family members for leadership positions or as peer to peer service providers does not depend on the availability of trained professionals. It does depend, however, on consumers and family members being in leadership positions to advocate for peer to peer services and leadership trainings, and this depends on how well professionals, support staff, and supervisors work with consumers and family members.

Limiting Community Preparation (B6, B7). Similar to B4 and B5, increasing the number of people *Receiving Appropriate Care and Support* increases *Caseloads*, which can slow the rate of *Adopting and Implementing EBP* as well as increase the rate of *Discontinuing EBP*. This limits the number of *Mental Health Workers Using EBP*, *Mentors for Implementing EBP*, *Training of Professionals, Support Staff, and Supervisors* and *Consumer and Family Driven Services*. The effect would be lower *Outcomes According to Families and Consumers*, slowing or decreasing *Quality of Life*, less *Consumer Empowerment*, and fewer *Consumers and Families in Leadership*. As a consequence, *Community Preparation* would slow down or decline, with fewer *Natural Supports*, and a corresponding increasing in *Populations Losing Appropriate Services*. That is, an increase in disparities, which would lead to more people *Losing Appropriate Care or Support* and forming two feedback loops, B6 and B7, as shown in Figure 7.

Figure 7 Limiting Community Preparation (B6, B7)



Discussion

This qualitative model provides a starting place for visualizing the interconnections involved in transformation for Missouri. The focus in this analysis has been on identifying the reinforcing and balancing feedback loops that could play important roles within the first two years of implementing recommendations. There are several observations to be made about the model.

First, training of professionals, support staff, and supervisors plays a central role in the constraints on transformation. More specifically, the main constraint from a feedback perspective is helping professionals gain experience and become mentors for training other professionals, particularly in the use of EBP and consumer and family driven services.

Second, many of the themes from the Leadership Meeting in July 2007 overlap with the implications from the model. For example, participants at the planning meeting discussed the importance of developing consumers and families in leadership positions and peer to peer services as development or growth mechanisms, and how these mechanisms could be used to develop local community support. These mechanisms are represented in model, which offers a more explicit conceptualization of which recommendations would generate change and how.

Third, it is important to remember that the model is a qualitative model and represents a collective understanding of services, supports, and transformation. The utility of such a model is in being able to synthesize diverse participants' views of services, supports, and transformation, and being able to logically trace the connections between variables. In this sense, it is similar to a logic model and could be used as a basis for theory based evaluations. The benefit of theory based evaluation is that it gives one a better understanding of why changes occurred and insights into the system. Like the scientific method, we learn the most when we make our hypotheses about change explicit and compare them against empirical data. Developing a quantitative system dynamics model that can be simulated would help make hypotheses even more explicit as well as generate insights into the relationships between populations, services, communities, and the dynamics of transformation.

Lastly, it will be helpful to remember that the most immediate threats to implementing recommendations come from the existing state of the system or stocks. Many of the recommendations in the plan focus on initiating change by affecting these stocks. Once some of these stocks are changing, reinforcing loops will accelerate change, followed by a set of constraints or balancing feedback loops that will slow down and potentially threaten both the sustainability of the initial benefits and the implementation of longer term policies.

Conclusion

Statewide transformation is inherently complex, involving many communities, stakeholders, and local, state, and federal agencies. The diversity of needs and level of cooperation required to successfully implement any single set of reforms requires high levels of communication, insight, leadership, and understanding for the system as a whole. Causal mapping of transformation goals and the development of a qualitative system dynamics model provide a new tool for decision makers to discuss, understand, and design changes that consider both the short-term and long term effects. Future work based on these efforts should focus on continuing to support the planning process, theory based evaluation efforts, and the development of a system dynamics simulation model that can be used for evaluation and learning.

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Appendix D—Glossary of Terms and Acronyms

ACE Goals: From the Strategic Plan of the Substance Abuse Mental Health Services Administration (SAMHSA), the ACE goals are Accountability, Capacity, and Effectiveness. Missouri's Transformation Initiative is funded by SAMHSA and the priority actions are measured for anticipated long-term impact using the ACE goals as designated below:

A-Improved Accountability
C- Increased Service Capacity
E-Increased Service Effectiveness

Alcohol and Drug Abuse (ADA) Division: one of the three divisions of the Missouri Department of Mental Health. ADA provides funding for prevention, outpatient, residential, and detoxification services to community-based programs that work with communities to develop and implement comprehensive coordinated plans. The Division provides technical assistance to these agencies and operates a certification program that sets standards for treatment programs, qualified professionals, and alcohol and drug related educational programs.

Bright Futures: Bright Futures is a cross agency effort supported by the Missouri Departments of Elementary and Secondary Education, Health, Mental Health, Social Services; Head Start; The Children's Trust; and the University of Missouri – Center for Mental Health Practices in Schools. Bright Futures mission is to help communities develop a professional, systematic, evidence based and sustainable team approach to address prevention, promotion and early intervention related to social emotional health of children

Burden of Disease: A measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability. (Also see Global Burden of Disease study and DALY) According to the World Health Organization, the proportion of the global burden of disease attributable to mental, neurological and substance use disorders is expected to rise from 12.3% in 2000 to 16.4% by 2020.More than 150 million persons suffer from depression at any point in time and nearly one million commit suicide every year. Moreover, there is strong evidence that mental disorders impose a range of consequences on the course and outcome of comorbid chronic conditions, such as cancer, heart disease, diabetes and HIV/AIDS.
http://www.who.int/mental_health/policy/en/Country%20activities%20table%20of%20contents.pdf

Causal Mapping: A method of developing causal loop diagrams that captures how variables in a system are related by cause and effect linkages.

Centers for Disease Control and Prevention (CDC): An agency located in the federal Department of Health and Human Services (DHHS), CDC seeks to promote health and the quality of life by preventing and controlling disease, injury, and disability. Principle functions include: monitoring health, detecting and investigating health problems, conducting research to enhance prevention, developing and advocating for sound public health policies, implementing prevention strategies, promoting healthy behaviors, fostering safe and healthful environments, and providing leadership and training.

Centers for Medicare and Medicaid Services (CMS): US federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Center for Mental Health Services (CMHS): CMHS is the part of the federal Substance Abuse Mental Health Services Administration under the Department of Health and Human Services. CMHS is responsible for mental health treatment and administers the CPS block grant as well as the Transformation grant

Center for Substance Abuse Prevention (CSAP): CSAP is the part of the federal Substance Abuse Mental Health Services Administration under the Department of Health and Human Services. CSAP is responsible for substance abuse prevention.

Center for Substance Abuse Treatment (CSAT): CSAT is the part of the federal Substance Abuse Mental Health Services Administration under the Department of Health and Human Services. CSAT is responsible for alcohol and drug abuse treatment. It is part of SAMHSA and administers the ADA block grant.

Children's Comprehensive System Management Team (CSMT): State legislation (SB 1003) mandated that DMH, in partnership with all child-serving departments, develop a unified, comprehensive children's mental health system. This legislation required a cross-departmental Comprehensive System Management Team responsible for developing and implementing a comprehensive mental health plan for children. The CSMT guides implementation of the children's components of this comprehensive plan.

Commission on Accreditation of Rehabilitation Facilities (CARF) A private, not-for-profit accrediting organization which establishes standards of quality for various service organizations to use as guidelines in developing and offering their programs or services to consumers. Service organizations voluntarily apply for certification and open themselves to survey and inspection. CARF is required by Vocational Rehabilitation for their providers.

Community Mental Health Center (CMHC): An entity designated by the MoDMH to serve as an organization providing services described in section 1916 (c)(4) of the Public Health Service Act that meets applicable licensing or certification requirements for community mental health centers in the state in which it is located. CMHCs provide outpatient services, including specialized services for children, the elderly, and persons with serious mental illness; 24-hour emergency care services; day treatment or other partial hospitalization services or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.

Comprehensive Psychiatric Services (CPS) Division: one of the three divisions of the Missouri Department of Mental Health. CPS is charged with the delivery of services to persons with mental illness throughout the State of Missouri. The division is committed to serving four target populations: persons with serious and persistent mental illness (SMI); persons suffering from acute psychiatric conditions; children and youth with serious emotional disturbances (SED) and forensic clients.

Consumer: Missouri is using and enhancing the term as defined in the President's New Freedom Commission Report. Consumer generally identifies people of all ages who use or have used mental health services and includes persons with mental illness, addiction disorders and mental retardation/developmental disabilities. In addition, the term extends to families/guardians who participate in services when they are not explicitly identified. The terms consumer, client and service participant are often used interchangeably with the same meaning.

Consumer Operated Service Programs (COSP): Services and supports directed by and employing consumers who have mental illness. For example, the CPS division contracts with these organizations for the provision of drop-in centers and warm lines.

Co-Occurring Disorders (COD): refers to co-occurring substance-related and other mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders. This term is also used to refer to co-occurring mental retardation or developmental disorders and one or more mental illnesses. The term COD is also used to refer to the specialized services provided to individuals with co-occurring disorders as in "COD services" or "COD program."

Co-Occurring State Incentive Grant (COSIG): SAMHSA-funded State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Disorders. Missouri received funding for five years through September 2008.

Crisis Intervention Teams (CITs): Local law enforcement teams who receive targeted training in how to respond and refer consumers needing mental health services in an effort to avoid inappropriate incarceration.

Department of Corrections (DOC): State department in Missouri that operates correctional facilities and monitors offenders on probation and parole.

Department of Mental Health (DMH): Missouri's public mental health authority. DMH has three divisions—Alcohol and Drug Abuse (ADA), Comprehensive Psychiatric Services (CPS) and Mental Retardation/Developmental Disabilities (MRDD).

Department of Health and Senior Services (DHSS): State agency in Missouri that works to improve the health and quality of life for persons of all ages by providing information and education, regulation and oversight, and quality services and surveillance of diseases and health conditions. Major divisions include: Community and Public Health, Regulation and Licensure, and Senior and Disability Services.

Department of Public Safety (DPS) The Missouri state agency which coordinates federal and state funds and programs for juvenile justice, victims' assistance, law enforcement, emergency management and narcotics control as well as support services and resources to assist local law enforcement agencies and to promote crime prevention. Major divisions include the State Emergency Management Agency, Homeland Security, Veterans Commission, Highway Patrol, Water Patrol, Gaming Commission, Alcohol & Tobacco Control, Fire Safety and Capitol Police.

Department of Social Services (DSS): State agency in Missouri responsible for coordinating programs to provide public assistance to children and their parents, access to health care, child support enforcement, and provide specialized assistance to troubled youth. Major divisions include: Children's Division, Family Support Division, MO HealthNet Division, and Division of Youth Services.

Departmental Client Number (DCN): Unique state identification number assigned by certain state departments. It is also referred to as Document Control Number**.**

Department of Elementary and Secondary Education (DESE): State department in Missouri that works with educators, legislators, government agencies, and citizens to maintain a strong public education system through statewide school improvement initiatives and regulatory functions. Major divisions of DESE include: Career Education, School Improvement, Special Education, Teacher Quality and Urban Education, and Vocational Rehabilitation.

Dialectical Behavioral Therapy (DBT) is a psychosocial treatment developed by Marsha M. Linehan specifically to treat individuals with borderline personality disorder (BPD), [1] though it is used for persons with other diagnoses as well. The treatment itself is based largely in behaviorist theory with some cognitive therapy elements as well. Unlike cognitive therapy it incorporates mindfulness practice as a central component of the therapy.

Disability Adjusted Life Years (DALY): The Disability Adjusted Life Year or DALY is a health gap measure that extends the concept of potential years of life lost due to premature death (PYLL) to include equivalent years of 'healthy' life lost by virtue of being in states of poor health or disability (1). The DALY combines in one measure the time lived with disability and the time lost due to premature mortality. One DALY can be thought of as one lost year of 'healthy' life and the burden of disease as a measurement of the gap between current health status and an ideal situation where everyone lives into old age free of disease and disability. http://www.who.int/healthinfo/boddaly/en/

Early Periodic Screening Diagnosis and Treatment (EPSDT): Program funded by Mo Healthnet (formerly Missouri Medicaid) also referred to as Healthy Children and Youth. Services include screening for physical development, vision, dental, and hearing; occupational therapy; physical therapy; psychological counseling; case management; immunizations; and other medically necessary services.

Electronic Medical Records (EMR): A medical record in digital format. Additional terms related to EMR include

- Bar-coded Point of Care Technology (BPOC)
- Computerized Physician Order Entry (CPOE)

Evidenced-Based Practices (EBPs): Standardized treatments studied in controlled research designs that are shown to improve important outcomes by objective measures, in research conducted by different investigator teams.

Federally Qualified Health Center (FQHC): A community based health care organization providing comprehensive primary preventive, health, dental, and mental health/substance abuse services to persons in all stages of the life cycle.

Fidelity: Fidelity is the extent to which an evidence-based practice actually implemented corresponds to the practice as designed. Following the design with high fidelity is expected to result in greater success in achieving desired client outcomes than deviating from the design (i.e., having low fidelity).

Global Burden of Disease (GBD) Project: World Health Organization (WHO) 2000 http://www.who.int/healthinfo/bodabout/en/index.html A response to the need for comprehensive, consistent and comparable information on diseases and injuries at global, regional and national levels. The WHO Global Burden of Disease (GBD) project updated the original Global Burden of Disease Study carried out by Murray and Lopez for the year 1990. The WHO GBD project draws on a wide range of data sources to develop internally consistent estimates of incidence, health state prevalence, severity and duration, and mortality for over 130 major causes, for WHO Member States and for sub-regions of the world, for the years 2000 and beyond. WHO program participation in the development and finalization of these estimates ensures that estimates reflect all information and knowledge available to WHO.

Government Performance Results Act of 1993 (GPRA). The Act provides for the establishment of strategic planning and performance measurement in the Federal Government. GPRA measures identified by SAMHSA for the purposes of evaluating the Transformation State Incentive Grant include the following measures of infrastructure changes:

1= Policy Changes Completed
2= # of Persons in Workforce Trained
3= Financing Policy Changes Completed
4= Organizational Changes Completed
5= # of Organizations that Regularly Obtain and Analyze Data
6= # of Members in Consumer and Family Run Networks
7= Programs Implementing Practices Consistent with CMHP

Health Literacy: http://www.iom.edu/Default.aspx?id=3827
Health literacy is the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. But health literacy goes beyond the individual. It also depends upon the skills, preferences, and expectations of those health information providers: our doctors, nurses, administrators, home health workers, the media, and many others. Health literacy arises from a convergence of education, health services, and social and cultural factors, and brings together research and practice from diverse fields.

Hippocrates: Greek physician who is credited with establishing the foundations of scientific medicine. He and his followers worked to distinguish medicine from superstition and magic beliefs by basing their treatment of illness on close observation and rational deduction.

Human Services Cabinet Council (HSCC): A Cabinet subgroup serving as the governing body of the Transformation Working Group and steering the mental health transformation process. The HSCC is chaired by the Governor's Chief of Staff. Members include the Directors of the Departments of Mental Health (DMH), Social Services (DSS), Health and Senior Services (DHSS), Elementary and Secondary Education (DESE), Corrections (DOC) and Public Safety (DPS).

Joint Commission (JC): formerly known as JCAHO, Joint Commission on Accreditation of Healthcare Organizations**):** An independent, not-for-profit organization, The Joint Commission accredits and certifies more than 15,000 health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards.

Lived experience: Is a sociology term referring to the way a person experiences and understands his or her world as real and meaningful. Lived experiences describe those aspects of a situation as experienced by the person.

Mental Disorders: As defined by the World Health Organization (WHO), mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behavior and relationships with others. The term is used interchangeably with "mental and behavioral disorders". The WHO definition is used as it includes mental health problems encountered by the majority of the populations addressed in this plan. The broad categories of mental and behavioral disorders covered in "International Classification of Diseases "manual (ICD-10) include:

- Organic, including symptomatic, mental disorders - e.g., dementia in Alzheimer's disease, delirium.
- Mental and behavioral disorders due to psychoactive substance use - e.g., harmful use of alcohol, opioid dependence syndrome.
- Schizophrenia, schizotypal and delusional disorders - e.g., paranoid schizophrenia, delusional disorders, acute and transient psychotic disorders.
- Mood [affective] disorders - e.g., bipolar affective disorder, depressive episode.
- Neurotic, stress-related and somatoform disorders - e.g., generalized anxiety disorders, obsessive-compulsive disorders.
- Behavioral syndromes associated with physiological disturbances and physical factors - e.g., eating disorders, non-organic sleep disorders.
- Disorders of adult personality and behavior - e.g., paranoid personality disorder
- Mental retardation - e.g., mild mental retardation.
- Disorders of psychological development - e.g., specific reading disorders, childhood autism.
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence - e.g., hyperkinetic disorders, conduct disorders, tic disorders.
- Unspecified mental disorder.

Mental Health Commission: The Mental Health Commission, composed of seven members, appoints the director of the Department of Mental Health with confirmation by the state Senate. Commissioners are appointed to four-year terms by the Governor, again with the confirmation of the Senate. The commissioners serve as principle policy advisors to the department director. The Commission by law must include an advocate of community mental health services, a physician who is expert in the treatment of mental illness, a physician concerned with developmental disabilities, a member with business expertise, an advocate of substance abuse treatment, a citizen who represents the interest of consumer developmental disability services.

Mental Health Literacy: Mental health literacy refers to the knowledge and beliefs about mental health problems which aid their recognition, management or prevention. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking. (See Health Literacy)

Mental Illness (MI): As defined by SAMHSA, a diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with

mental disorder. (From SAMHSA National Strategy for Suicide Prevention Glossary http://mentalhealth.samhsa.gov/publications/allpubs/SMA01-3517/appendixe.asp)

Mental Retardation/Developmental Disabilities (MRDD): One of the three divisions of the Missouri Department of Mental Health. MRDD, established in 1974, serves a population that has developmental disabilities such as mental retardation, cerebral palsy, head injuries, autism, epilepsy, and certain learning disabilities. Such conditions must have occurred before age 22, with the expectation that they will continue. To be eligible for services from the Division, persons with these disabilities must be substantially limited in their ability to function independently

MSNT: Midwest Special Needs Trust http://www.midwestspecialneedstrust.org/
Midwest Special Needs Trust (MSNT) provides trust services for persons with disabilities. The organization was established as a result of advocacy by parents and professionals who realized that many obstacles hinder planning for the financial future of individuals with disabilities.

Missouri Primary Care Association (MPCA): http://www.mo-pca.org/
The MPCA is a non-profit corporation founded in November 1984 as an alliance of community health centers. The Association functions as an advocacy voice for the medically underserved and explores and implements activities aimed at providing and promoting high quality, accessible, and personalized healthcare services to urban and rural populations - regardless of ability to pay - in the state of Missouri. MPCA's mission is to be Missouri's leader in shaping policies and programs that improve access to high-quality, community-based, and affordable primary health services.

MO-ANCOR: http://www.moancor.org/
The American Network of Community Options and Resources - Missouri Chapter is an organization that assists providers in empowering people who experience developmental disabilities to: (1) exercise maximum control over their lives; and (2) experience full inclusion in their communities through a choice of various supports and services. The mission of MO-ANCOR is the promotion of and assistance to private or county providers who offer services and supports to people with disabilities and their families through advocacy, information and education.

Missouri Association of Rehabilitation Facilities (MARF): http://www.marf.cc
MARF is the trade association for organizations serving people with disabilities and others who need community support. The mission of MARF is to provide leadership and a statewide coalition to enhance the lives of Missourians who need community supports through legislative initiatives, partnerships with state agencies, and professional development

Missouri Association of County Developmental Services (MACDDS): http://www.macdds.org
The Missouri Association of County Developmental Disabilities Services (MACDDS) is a leader in local initiatives for people with developmental disabilities. The organization is comprised of 45 county boards with total expenditures exceeding $117.6 million a year, providing local services for more than 46,000 people with developmental disabilities. Members also invest over $8 million in partnership with the state Department of Mental Health - Division of MR/DD in the Medicaid Waiver. MACDDS is dedicated to ensuring that quality community supports are available for people with developmental disabilities.

Missouri Autism Center for Excellence (MO-ACE):
http://www.nichd.nih.gov/news/releases/investigate_causes_autism_080207.cfm
The Missouri Autism Centers of Excellence (MO-ACE) consists of three University-based providers of autism services that have been selected to enhance the state's efforts to accelerate the pace of early diagnosis and treatment for individuals with autism spectrum disorders (ASD) and their families.

Missouri Autism Response and Research Agenda (MARRA): A collaborative of multiple stakeholders and partnership with University of Missouri Thompson Center on Autism and neuro-developmental disabilities

Missouri Coalition of Community Mental Health Centers (MOCCMHC): The Missouri Coalition of Community Mental Health Centers, founded in 1979, represents Missouri's not-for-profit community mental health centers (CMHCs), as well as alcohol and drug abuse treatment agencies. The MOCHMC represents twenty-eight member agencies that provide mental health treatment and support services across the state.

Missouri Housing Development Commission (MHDC): MHDC is the state's housing finance agency. The Commission is dedicated to strengthening communities and the lives of Missourians through the financing, development and preservation of affordable housing.

Missouri Institute of Mental Health (MIMH): A policy, research and training center at the University of Missouri-Columbia, the MIMH is dedicated to providing research, evaluation, policy and training expertise to the Missouri Department of Mental Health, other state agencies, service provider agencies, and other organizations and individuals seeking information related to mental health and other related policy areas. Specific areas of interests include substance abuse prevention and treatment, mental health promotion and treatment, mental health and substance abuse recovery, suicide prevention, violence prevention, behavioral health, behavioral informatics, epidemiology, and health literacy. Areas of expertise include quantitative and qualitative research methods, information technology, web site design and applications, process and outcome evaluation, and program and curriculum development.

Missouri Mental Health Task Force: A one-time group charged with developing long-term solutions to prevent abuse and neglect, assure thorough investigation of abuse and neglect allegations, and recommend actions to increase the safe delivery of mental health services for Missourians with disabilities. This task force was formed at the direction of Governor Matt Blunt to oversee a cross-agency effort to address incidents of abuse and neglect and client deaths at Department of Mental Health facilities and community-based agencies. The task force was made up of the Departments of Mental Health (DMH), Public Safety (DPS), Health and Senior Services (DHSS), and Social Services (DSS). Lt. Governor Peter Kinder and Ron Dittemore, interim director for DMH, served as co-chairs. See Findings and Recommendations of this task force at: http://www.dmh.missouri.gov/mmhtaskforce/.

Missouri Planning Council for Developmental Disabilities (MPCDD): A federally funded, 23-member council, appointed by the Governor. Its mission is to assist the community to include all people with developmental disabilities in every aspect of life. By law, 60 percent of the council's membership consists of individuals with developmental disabilities and family members. The remaining 40 percent is made up of key representatives from state agencies that provide services and supports to people with developmental disabilities.

Missouri Substance Abuse Prevention, Intervention and Resources Initiative (Spirit) Program: supports development/ implementation of a continuum of evidenced-based substance abuse prevention services in K-12 public schools.

Mo Blue Ribbon Panel on Autism: http://www.senate.mo.gov/autism/autism2007.pdf
The Blue Ribbon Panel consisted of sixteen members and was established to assist policymakers in providing a better system for individuals and their families affected by Autism Spectrum Disorders. The Blue Ribbon Panel was charged with identifying issues of children, youth, and adults with autism and with making appropriate recommendations to address those identified needs. The Blue Ribbon Panel heard over 60 hours of testimony in 5 cities (Jefferson City, Cape Girardeau, Springfield, St. Louis, and Kansas City) from numerous experts, families, and individuals with ASD.

Needs Assessment & Resource Inventory (NARI): A comprehensive statewide mental health needs assessment and resource inventory conducted by the Missouri Institute of Mental Health (MIMH) for the purpose of assisting in the development of the Comprehensive Mental Health Plan. MIMH researchers gathered information from a variety of individuals and organizations involved in Missouri's mental health care system including consumers, provider agencies, state agency personnel, other professionals and the general population. Numerous focus groups, key informant interviews and surveys were conducted as

part of the needs assessment. A special effort was made to engage persons whose voices were underrepresented through focus groups and key informant interviews. The NARI serves as a companion document to this plan. MIMH will distribute this document and it is also posted on the Transformation website at: http://www.dmh.mo.gov/transformation/transformation.htm.

Network of Care (NOC): http://missouri.networkofcare.org/home_state.cfm?stateid=30
Network of Care is a highly interactive, single information place where consumers, community-based organizations and municipal government workers all can go to easily access a wide variety of important information. The resources in this "virtual community" include a fast, comprehensive service directory; links to pertinent Web sites from across the nation; a comprehensive, easy-to-use Library; a political advocacy tool; community message boards; and many others.

Office of Administration (OOA): http://www.oa.mo.gov/
The Office of Administration provides guidance and assistance to state government entities through the implementation of executive office initiatives, the establishment of uniform procedures and rules as well as providing services to them in a cost-effective manner.

Office of Juvenile Justice and Delinquency Prevention (OJJDP): Part of the U.S. Department of Justice, this agency provides national leadership, coordination, and resources to prevent and respond to juvenile delinquency and victimization. OJJDP supports states and communities in their efforts to develop and implement effective and coordinated prevention and intervention programs, and to improve the juvenile justice system so that it protects public safety, holds offenders accountable, and provides treatment and rehabilitative services tailored to the needs of juveniles and their families.

Office of State Court Administrators (OSCA): A state courts administrator functions under direction of the Supreme Court to help develop and implement administrative policies and services for the judicial branch. The Missouri state courts administrator's office ensures court operations and judicial administrative needs are identified, evaluated and incorporated into appropriate long- and short-range plans; establishes priorities and secures resources to accomplish those priorities; addresses financial and operational problems and budgeting issues; and manages use of technology within the judicial branch. (http://www.courts.mo.gov/page.asp?id=631)

Outcomes: Specific, measurable results used to judge the effectiveness of an intervention.
Person-Centered Planning: Person-centered planning is a process-oriented approach to empowering people that has been adopted in the developmental disabilities field. The person-centered approach relies much less on the service system by organizing truly individualized, natural, and creative supports to achieve meaningful goals based on the individual's strengths and preferences

Positive Behavioral Support (PBS): A set of research-based strategies to enhance the capacity of schools, families, and communities to design effective teaching and learning environments. It is a collaborative, assessment-based process to develop effective, individualized interventions for individuals with challenging behavior. Support plans focus on proactive and educative approaches. In school settings, it focuses on creating and sustaining school-wide (primary), classroom (secondary), and individual (tertiary) supports that improve lifestyle results for all students by making problem behavior less effective, efficient, and relevant, and desired behavior more functional. Use of PBS decreases the need for interventions such as punishment or suspension.

Prevention: Beginning with public health, prevention is generally categorized as *primary* prevention, directed at averting a potential health problem; *secondary* prevention, directed at early detection and, as appropriate, intervention to delay onset or mitigate a health problem; or *tertiary* prevention, directed at minimizing disability and avoiding relapse. In practice, prevention technologies take three general forms in clinical practice: (1) prevention strategies that are usually delivered on a one-to-one basis within the context of traditional medical care; (2) behavioral prevention strategies, sometimes referred to as health promotion, that focus on adopting lifestyles conducive to health; and (3) environmental prevention strategies that are undertaken by a community to safeguard the well-being of all citizens (Teutsch, 1992).

In its 1994 report, *Reducing Risks for Mental Disorders: Frontiers for Prevention Intervention Research*, the Institute of Medicine (IOM) proposed a more targeted set of definitions related to behavioral health, correlated with levels of health risk in target populations (Mrazek & Haggerty, 1994). These definitions are based upon a classification proposed more than a decade earlier (Gordon, 1983). The "continuum of care" spectrum that encompasses these three classifications within the IOM Model of Prevention are:

- *Universal* interventions, offered to an entire population because their benefits outweigh their cost and risk;
- *Selective* interventions, targeted only to groups at greater risk than the rest of the population, incurring a moderate cost justified by the increased risk of illness; and
- *Indicated* interventions, provided only to high-risk individuals and to those persons who are experiencing early symptoms of a disorder either to prevent future development of a health problem or to reduce the duration or severity of a health problem. http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3437/SMA00-3437ch3.asp

Procovery™: www.procovery.com Developed by Kathleen Crowley, Procovery is a process whereby individuals with serious and/or chronic mental or physical illnesses and injuries can build healthier and more fulfilling lives, notwithstanding the possible continuing presence or worsening of symptoms. It is based on the ability to move forward by taking small, ordinary, individual actions toward a holistic integration of one's illness or disability into life. It is both a means and an end that refocuses one's attention, away from illness and loss, and on faith in the future potential of one's life. The practical application of Procovery in Missouri includes a structured small group process (Procovery Circles) that can include consumers, families, professionals and community members as part of the group.

ACT Assertive Community Treatment (ACT): A model of delivering services and supports to adults with serious mental illness. Multidisciplinary teams including physicians, nurses, substance abuse specialists, vocational specialists, and case managers deliver all necessary services.

Provider: A recognized and appropriately credentialed individual or organization that delivers mental health services and supports.

Psychiatric Advance Directives (PAD): A legal document created by a competent person that allows the person to give instructions for future mental health treatment or appoint an agent to make future decisions about mental health treatment.

Respect Seminars and Institutes: RESPECT Seminars are designed to train professionals, family members and peers in the fundamentals of caring for persons with mental health challenges. The week-long RESPECT Institute is designed to provide 12 consumers the skills and coaching necessary to transform their mental illness, treatment, and recovery experiences into educational and inspirational presentations.

Quality Service Review (QSR): A broad term for a set of processes and tools designed to review human service systems. It is based on an in-depth case review method involving multiple stakeholders, and uses a performance appraisal process to assess how service recipients benefit from services and how well service systems address their needs.

Recovery: As defined in the President's New Freedom Commission on Mental Health (NFCMH), recovery is "the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms" (NFCMH, 2003, p. 5).

Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA is the section of the federal Department of Health and Human Services that is responsible for alcohol, drug abuse and mental health services. It has three centers including the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT) and the Center for Substance Abuse Prevention (CSAP).

Serious Emotional Disturbance (SED): Term used to describe children and youth who have serious disturbances in psychological growth. In Missouri the definition includes children and youth under the age of 18, with substantial impairments in their ability to function at developmentally appropriate levels, have a serious Axis 1 psychiatric disorder as defined in the DSM-IV, at risk of out of home placement, who require two or more agencies/services to address the disorder.

St. Louis Regional Health Commission (SLRHC): http://www.stlrhc.org/
The RHC is a collaborative effort of St. Louis City, St. Louis County, the state of Missouri, health providers, and community members to improve the health of uninsured and underinsured citizens in the greater St. Louis area. The Commission has spearheaded a behavioral health transformation initiative in the eastern region of Missouri in collaboration with Missouri's mental health transformation project.

Stakeholder Advisory Group (Children) (SAG): State legislation (SB 1003) required DMH to establish a stakeholder advisory committee to provide input to the CSMT and to assist in developing strategies to ensure positive outcomes for children. The SAG membership requires a majority of family and youth representation. By incorporating children's policy and planning to the TWG, the SAG serves a principle advisory role to both the TWG and CSMT.

State Advisory Council (SAC) for Comprehensive Psychiatric Services (CPS): The SAC is comprised of 25 members who advise the Division of CPS in the development and coordination of a statewide interagency and inter-departmental system of care for persons with mental illness, their families, and children and youth with Serious Emotional disturbances (SED). The Council membership is required by federal law to have a majority of mental health consumers, including parents of children receiving services and family members. In addition, representation is required from the following state agencies: Social Services, MO HealthNet, Corrections, Vocational Rehabilitation, Education, Housing and Mental Health. The remainder of the council is made up of private and state-contracted providers, Missouri Protection and Advocacy, and other advocacy groups.

State Advisory Council (SAC) for ADA The Council serves as an advisory body to the Division of Alcohol and Drug Abuse of the Missouri Department of Mental Health and Division Director. The Council is created by Missouri Statute, to be found in Section 631.020, Missouri Revised Statutes.

Stigma: Stigma refers to unfavorable attitudes and beliefs directed toward someone or something. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. The word is often applied to personal attributes that are considered shameful or discrediting. The 1999 Report on Mental Health by the Surgeon General of the United States was regarded as a landmark document because of its straightforward identification of the stigma associated with mental disorders as the chief obstacle to effective treatment. The report states that "stigma leads others to avoid living, socializing or working with, renting to, or employing people. It reduces people's access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society."

Transformation Working Group (TWG): The TWG is a Governor-appointed board established through Executive Orders 06-39 and 07-15. Members include key Governor's Office and departmental senior leaders, consumer and family experts, and other public leaders. The chairpersons and principle staff are based in the DMH Director's Office to lead the planning process in partnership with other mental health services agencies. The principle responsibility of the TWG is to 1) create a Comprehensive Mental Health Plan for Missouri that transcends state department boundaries and fully integrates the current Comprehensive Children's Mental Health Plan, and 2) lead the implementation of the plan once developed.

Trauma Informed Care: Trauma-inducing experiences, including physical and sexual abuse, often leads to mental health and other types of co-occurring disorders such as health problems, substance abuse

problems, eating disorders, HIV/AIDS issues, and contact with the criminal justice system. When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma impacts people's lives. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

Warm lines. A phone service designed to solve relatively minor problems or to prevent those problems from becoming serious.
http://www.wordspy.com/words/warmline.asp

Wrap-around planning: Typically applied in children's service settings**,** the wraparound process is a way to improve the lives of consumers who have complex needs. It is not a program or a type of service. The process is used to help communities develop individualized plans of care. The actual individualized plan is developed by a Wraparound Team, the four to ten people who know the consumer best. The plan is needs-driven rather than service-driven, although a plan may incorporate existing categorical services if appropriate to the needs of the consumer. Planning, services, and supports cut across traditional agency boundaries through multi-agency involvement and funding. Governments at the provincial, state, district, regional and local levels work together to improve services. Outcome measures are identified and individual wraparound plans are frequently evaluated.

Appendix E: Missouri Mental Health Transformation Logic Model

Strategic Themes

Creating Communities of Hope; Moving Missouri Toward a Public Health Approach

From Culture of Crisis/ Risk of Harm to Culture of Hope/First: Do No Harm"
From No Where to Go to Easy, Early and Equal Access
From Disability Focus to Wellness Focus with Prevention and Early Intervention
From Bureaucracy/Provider-Driven Care to Consumer Direction & Empowerment
From "Pockets" of Excellence to Universal Best Practices
From Fragmented & Centralized System to Shared Ownership and Investment (State-Local-Private)

Missouri's Vision of a Transformed System

Communities of Hope Throughout Missouri

Levers of Change

International
- WHO MH report

National
- New Freedom Comm.
- MH Reports: Surgeon General's, IOM, National Business Roundtable
- Deficit Reduction Act

State
- Legislation: i.e., MH Parity, Suicide Prevention
- Children's MH Reform Act
- MO Medicaid Reform
- Rural MH Access Assess.
- Local Collaboratives
- Federal Grants: SAMHSA & CMS i.e., Co-SIG, Systems of Care, SPF SIG, MRDD Transformation
- MO Blue Ribbon Panel on Autism
- Lt.Gov's MH Task Force on Safety

Planning Process

Structure

Governor's Office
Human Services Cabinet Council

TWG
Office of Transformation

6 Content Work Groups

Resources & TA

Stakeholders
Individuals
Families
Communities
Providers
Professional & Trade Associations
Educational & Research Institutions
Foundations
Payers
Advocacy Organizations
Oversight Organizations
Federal, State and Local Government

Goals

Missourians Understand that Mental Health is Essential to Overall Health

Missouri's Mental Health System is Consumer & Family Driven

Mental Health Disparities are Eliminated in Missouri

Early Mental Health Screening, Assessment & Referral Services Are Common Practice in Missouri

Excellent Mental Health Care Is Delivered and Research is Accelerated

Missouri Communities are Proficient in Meeting Local Mental Health Needs

Objectives and Strategies

- Public Education
- Stigma Reduction
- Promotion/Prevention Consumer & Families as Decision-makers
- Peer Support Services
- Evidence-based Practices
- Innovation & Research
- State Collaboration
- Local Collaboration
- Integrated Care
- Increase Access
  - Rural
  - Culturally & Linguistically Appropriate services
- Employment, Housing & Transportation

Cross-cutting Strategies
- Technology
- Workforce Development

Outcomes

Infrastructure Changes
- Policy & Financing
- Service/program Development
- Workforce Training & Development
- Organizational Structure & Culture

System Outcomes
- Safe & Effective Care
- Culture of Respect & Wellness
- Adequate & Competent Workforce
- Consumers Involved in Policy, Care & Evaluation
- Collaboration & Shared Decision-Making
- Increased Access & Capacity
- Data-Driven Decisions

Individual:
- Resiliency & Wellness
- Self-determination
- Community Tenure
- Improved Health Status
- School Success
- Employment Success
- Stability in living Conditions
- Social supports & connectedness

Community
- Reduced Stigma
- Decreased Disability
- Improved Mental Well-being
- Improved Mortality Rates
- Increased Real Investment in Mental Health

Evaluation